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CIS

VA/DOD HEALTH-CARE RESOURCES SHARING ACT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

ON

S. 266 and Related Bills

JUNE 17, 1981

Printed for the use of the Committee on Veterans' Affairs

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CONTENTS

Page

Opening statement of Hon. Frank H. Murkowski, acting chairman of the Senate Committee on Veterans' Affairs 1

Bill S. 266, as reported by the Committee on Governmental Affairs and referred to the Committee on Veterans' Affairs:
- Text of 4
- Agency reports of—
  - Department of Defense (No. 20, June 19, 1981) 13
  - Veterans' Administration (No. 49, August 12, 1981) 15
  - Office of Management and Budget (No. 52, August 12, 1981) 20
- Amendment No. 62, June 9, 1981 21
  - Statement of Hon. Alan Cranston, excerpt from the Congressional Record, June 9, 1981 32
- Agency reports of:
  - Veterans' Administration (No. 53, September 15, 1981) 33
  - Federal Emergency Management Agency (No. 54, September 24, 1981) 39

Testimony of:
- Hon. Charles H. Percy, a U.S. Senator from the State of Illinois 40
- Gregory J. Ahart, Director, Human Resources Division, U.S. General Accounting Office, accompanied by David P. Baine, Group Director, Human Resources Division; and Darryl W. Dutton, Senior Evaluator, Los Angeles Regional Office 45
- Dr. John H. Moxley III, Assistant Secretary of Defense (Health Affairs), Department of Defense, accompanied by Lt. Col. Podge Reed and Lt. Col. David Burke 82
- Dr. Donald L. Custis, Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration, accompanied by Ralph Ibson of the General Counsel's Office, and Dr. Carl Hughes, Assistant Chief Medical Director for Professional Services 95
- John W. McConnell, Acting Associate Director, Plans and Preparedness, Federal Emergency Management Agency, accompanied by George Jett, General Counsel, and Fredrick Haase 145
- Donald Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States 168
- E. Philip Riggin, deputy director, National Legislative Commission, the American Legion, accompanied by Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission 176
- Gabriel P. Brinsky, national service and legislative director, AMVETS 188
- John F. Heilman, national legislative director, Disabled American Veterans 195

Written statement of:
- Hon. George J. Mitchell, a U.S. Senator from the State of Maine 44
- Hon. Strom Thurmond, a U.S. Senator from the State of South Carolina ... 44
- Gregory J. Ahart, Director, Human Resources Division, General Accounting Office 48
- Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 81
- Dr. Donald L. Custis, Chief Medical Director, Department of Medicine and Surgery, Veterans' Administration 99
- Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States 170
- Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission, the American Legion 179
- Gabriel P. Brinsky, national service and legislative director, AMVETS 189

Written statement of—Continued
Page
- John F. Heilman, national legislative director, Disabled American Veterans 197

Questions and answers:
- Response of the General Accounting Office to written questions submitted by:
  - Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs 65
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 68
- Response of the Department of Defense to written questions submitted by:
  - Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs 88
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 91
- Response of the Veterans' Administration to written questions submitted by:
  - Hon. Alan K. Simpson, Chairman of the Senate Committee on Veterans' Affairs 110
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 115
- Response of the Federal Emergency Management Agency to written questions submitted by:
  - Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs 147
  - Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs 154

Letters to:
- Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs, from:
  - E. Philip Riggin, director, National Legislative Commission, the American Legion, dated July 10, 1981 187
  - Gabriel P. Brinsky, national service and legislative director, AMVETS, dated July 6, 1981 194
  - R. Jack Powell, executive director, Paralyzed Veterans of America, dated July 6, 1981 211

APPENDIXES

Appendix A.—GAO Report entitled "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System," dated June 26, 1980 215
Appendix B.—Excerpts from Senate Report No. 96-137 to S. 266, June 15, 1981 276
Appendix C.—Bill S. 266, as reported by the Committee on Veterans' Affairs, with an amendment and an amendment to the title, September 29, 1981 287
Appendix D.—Excerpts from the Senate Report No. 97-196 to S. 266, September 29, 1981 308
Appendix E.—Bill H.R. 3502, as reported by the House of Representatives Committees on Armed Services and Veterans' Affairs, October 27, 1981 and May 7, 1981 336
Appendix F.—House of Representatives Report No. 97-72 to H.R. 3502:
- Part 1 (May 19, 1981) 348
- Part 2 (October 27, 1981) 372

Appendix G.—Excerpts from the Congressional Record on the Senate passage of S. 266, October 27, 1981 394
Appendix H.—Excerpts from the Congressional Record on the passage of the Senate amendments (unprinted amendment No. 871) to the House amendments to S. 266, April 1, 1982 407
Appendix I.—Public Law 97-174, 97th Congress, May 4, 1982 425

VA/DOD HEALTH-CARE RESOURCES SHARING ACT

WEDNESDAY, JUNE 17, 1981

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9:38 a.m., in room 412, Russell Office Building, Hon. Frank H. Murkowski (acting chairman of the committee) presiding.

Present: Acting Chairman Frank H. Murkowski (presiding) and Senator George J. Mitchell.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, ACTING CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Senator MURKOWSKI. Good morning. We will call the committee hearing to order.

Before we actually begin this morning's hearing, I want to note my great disappointment that the committee has not received a formal administration position on the pending legislation by the 48-hour deadline required by the committee rules, and that in fact we did not have the VA or DOD testimony by 9 o'clock this morning.

This is plainly unacceptable, especially since none of the measures before the committee are new ones. S. 266 was introduced a number of months ago, and the provisions of amendment No. 62 are derived from H.R. 3502, which was introduced early in May.

Although we will proceed this morning with the hearing, the committee will not mark up this legislation as scheduled next week. Rather, the markup will be delayed to some as yet undecided date in the future, so that the committee will have the opportunity to receive and analyze the administration's position, and to ask followup questions on that position.

It is also possible that there may be a further hearing as necessary prior to markup. I would hope that the witnesses here today from the executive branch will relay the committee's great dissatisfaction with the way in which testimony was cleared for today's hearing through the Office of Management and Budget.

This morning we are going to examine two related legislative proposals designed to foster a closer working relationship between the Veterans' Administration and the Department of Defense health-care systems. The first emphasizes peacetime opportunities to reduce health-care costs and enhance health care for beneficiaries of each program. The second is designed to facilitate medical treatment of members of the Armed Forces during a period of war or national emergency.

The Veterans' Administration and the Department of Defense both operate major health-care systems serving large numbers of Federal beneficiaries. Sharing of resources between the two systems would appear to be a reasonable way of improving access to care while constraining cost increases.

The Veterans' Administration, along with other agencies, has a mechanism for sharing under the Economy Act, and has specific authority to share specialized medical resources. However, previous reports have indicated that a clear statement of congressional intent and elimination of certain disincentives would accelerate sharing among facilities.

The examples of scattered resource sharing which have been cited previously might become models for a significant national program. The local and regional planning which would be required might even become a future necessity as health technology becomes more sophisticated and expensive. Recent debates in Congress and in planning agencies throughout the country over the dissemination of computed tomography, the CAT scanners, has heightened public interest in the problem just as new generations of equipment, such as positron emission tomography, are approaching introduction. If Federal beneficiaries are to share the benefits of costly new technology, they will have to share access as well if it is to be affordable. It is timely that we consider sharing now to assure availability and access in the future.

Such sharing would have the additional benefit of establishing working relationships between the Veterans' Administration and the Department of Defense which would facilitate a coordinated response to the medical needs arising from a state of war or national emergency. The VA apparently has been reluctant to make long-term commitments to the Defense Department since treatment of active members of the Armed Forces is subject to availability of resources. Presumably, under an emergency mobilization, the VA would be authorized to accept active duty patients, but such a presumption cannot be the basis for effective anticipatory planning.

Previous estimates of the Defense Department's active hospital bed capacity have indicated serious limitations in ability to respond to a major influx of casualties. There are many locations, both in the United States and abroad, where large numbers of members of the Armed Forces are on duty. They could be subject to enemy attack—conventional, chemical, or nuclear in nature—as well as natural or manmade catastrophies.

The Department of Defense has no more than 20,000 staffed operational beds. Following an enemy attack or major disaster, it is likely that most casualties would have to be treated in other facilities. The Government Accounting Office has concluded that contingency planning should begin with appropriate use of Federal medical resources before calling on civilian resources.

The proposed legislation would: One, create a contingency planning process; two, establish a priority for active duty members of the Armed Forces for VA treatment during war or national emergency; and three, provide for contracts with private facilities to meet the emergency needs of veterans displaced by battlefield casualties. In effect, this would create a new mission for the Veterans' Administration as the primary civilian medical reserve to the Department of Defense.

The bills, agency reports, and related materials will be inserted in the record at this point.

[The text of the bills S. 266 and S. 636, agency reports thereon, and other related materials follow:]

97TH CONGRESS
1ST SESSION

S. 266

[Report No. 97–137]

To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources.

IN THE SENATE OF THE UNITED STATES

JANUARY 27 (legislative day, JANUARY 5), 1981

Mr. PERCY (for himself, Mr. COHEN, Mr. DURENBERGER, and Mr. PROXMIRE) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

JUNE 15 (legislative day, JUNE 1), 1981

Reported by Mr. ROTH, without amendment, and referred, pursuant to the order of June 4, 1981, to the Committee on Veterans' Affairs for not to exceed forty-five days

---

A BILL

To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Interagency Medical Resources Sharing and Coordination Act of 1981".

FINDINGS AND PURPOSES

SEC. 2. (a) The Congress finds that—

(1) coordination among Federal agencies in the use of Federal medical resources would minimize duplication and underutilization of Federal direct health care facilities, reduce costs, and enhance health care;

(2) optimum coordination between the Veterans' Administration and Department of Defense, the largest Federal providers of direct health care, would reduce health care costs and, in many cases, improve the quality of, and access to care available to Federal beneficiaries;

(3) greater interagency sharing of medical resources between the Veterans' Administration and the Department of Defense may be achieved without a detrimental effect on each agency's primary beneficiaries;

(4) currently there are not adequate incentives in the various Federal direct health care delivery systems to encourage maximum interagency use of Federal medical resources;

(5) the Veterans' Administration and the Department of Defense should, to the extent feasible within each agency's responsibilities, share medical resources and increase the coordination of medical care; and

(6) the establishment of an interagency committee will facilitate interagency sharing of medical resources between the Veterans' Administration and the Department of Defense.

(b) It is the purpose of this Act to (1) clarify and expand the authority of the Veterans' Administration and the Department of Defense as direct health care providers in order to facilitate Federal interagency sharing of medical care and medical care support resources and (2) establish an interagency committee to serve as a mechanism to encourage maximum interagency sharing of such resources.

DEFINITIONS

SEC. 3. As used in this Act, the term—

(1) "direct health care" means any health care provided to an eligible beneficiary in a facility operated by the United States Government, including inpatient care and any type of outpatient treatment, testing, or examination;

(2) "beneficiary" means any individual who is entitled by law to direct health care furnished by the Veterans' Administration or the Department of Defense;

(3) "providing agency" means the Veterans' Administration or the Department of Defense;

(4) "primary beneficiary" means an individual who is specifically entitled by law to direct health care in the facilities of a particular providing agency;

(5) "negotiated cost" means the cost determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the services provided; and

(6) "medical resource" means medical care and medical care support resources.

INTERAGENCY FEDERAL MEDICAL CARE COORDINATION

SEC. 4. (a) There is established a Federal Interagency Medical Resources Committee (hereafter in this Act referred to as the "Committee"). The Committee shall be composed of the Secretary of Defense and the Administrator of Veterans' Affairs or their designees. In order to establish policies applicable to the Veterans' Administration and the Department of Defense as Federal direct health care providers with regard to interagency sharing of medical resources, the Committee shall, notwithstanding any other provision of Federal law relating to interagency sharing of medical resources, undertake the following:

(1) Assess the opportunities for interagency sharing of existing medical resources between the Veterans' Administration and the Department of Defense.

(2) Remain continuously apprised of the planning of any additional Veterans' Administration or Department of Defense medical facilities, including the location of new facilities and the acquisition of major new medical equipment, with regard to the impact of such plans on opportunities for interagency sharing.

(3) Review existing Veterans' Administration and Department of Defense direct health care capabilities, including support and administrative services, to identify sharing opportunities that will not adversely affect the quality of, or the established priority of, care provided.

(4) Prescribe policies and procedures designed to maximize the interagency sharing of the Veterans' Administration and the Department of Defense medical resources.

(5) Coordinate the establishment of uniform interagency health care policies and procedures for providing agencies and monitor the implementation of such policies and procedures, including policies and procedures for coordinated planning for future development of each agency's direct health care delivery system.

(6) Consult, when appropriate with regard to carrying out the matters described in paragraphs (1) through (5), with other Federal providers to encourage

optimum coordination in the delivery of direct health care.

(7) Prescribe uniform guidelines, within one hundred and eighty days after the date of the enactment of this Act, to directors and commanding officers of health care facilities within the Veterans' Administration and the Department of Defense for the sharing of medical resources by such health care facilities. Such guidelines shall provide, consistent with the policies and procedures developed under this Act, for the following:

(A) The director or commanding officer of each health care facility within the jurisdiction of the Veterans' Administration and the Department of Defense shall, whenever possible, enter into interagency cooperative sharing arrangements with other health care facilities of such providing agencies. Under such arrangements, a beneficiary eligible for direct health care in one agency's facility may receive medical care at a providing facility of the other agency.

(B) Services to be shared may include any medical resource.

(C) Medical resources to be shared shall be negotiated by the directors or commanding officers of the health care facilities entering into an arrangement.

(D) The availability of direct health care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the quality of care and priority access for medical services of the providing agency's beneficiaries.

(E) Whenever a beneficiary receives medical services from a providing agency other than the particular providing agency for which such beneficiary is a primary beneficiary, such providing agency shall be reimbursed based on negotiated costs as agreed by the directors or commanding officers of the participating health care facilities.

(F) Reimbursement shall be credited when received by the providing agency to the specific facility that provided the medical service.

(G) Sharing arrangements shall be operative upon agreement of the directors or commanding officers entering into such arrangements unless disapproved upon submission to each agency.

(b) Nothing in this Act shall be construed to preclude sharing of medical resources among all Federal direct health care providers pursuant to any other law.

(c) The responsibilities of the Committee under this Act with regard to uniform direct health care shall not be construed to alter any providing agency's responsibilities with regard to the provision of medical services provided by law.

(d)(1) The Committee shall, within one year after the date of the enactment of this Act, prepare and transmit to the Congress a report, including such legislative recommendations as the Committee considers appropriate, with regard to—

(A) the guidelines prescribed pursuant to subsection (a)(6);

(B) the opportunities for interagency sharing as required in section 4(a)(1);

(C) the interagency sharing arrangements entered into by health care facilities of such providing agency;

(D) each providing agency's activities pursuant to cooperative interagency sharing arrangements;

(E) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

(F) the progress of Federal interagency medical resource sharing;

(G) the interagency coordination of Federal health resources planning; and

(H) other major Federal activities to increase interagency sharing of Federal medical resources.

(2) Each year at the time the President transmits the Budget under section 201(a) of the Budget and Accounting Act, 1921, beginning with the year after the year in which the Committee submits its report under paragraph (1), the Committee shall prepare and transmit to the Committees on Appropriations of the Senate and the House of Representatives a report for the preceding year containing the information described in paragraph (1).

[No. 20]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,
Washington, D.C., June 19, 1981.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for views of the Department of Defense on S. 266, a bill "To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources."

In addition to the establishment of an interagency committee as specified in the title, the purpose of the bill is to expand the authority of the Department of Defense and the Veterans' Administration to facilitate interagency sharing of medical resources.

The bill provides incentives to encourage greater interagency sharing thereby improving access to health care and reducing costs by minimizing duplication and underutilization of Federal medical resources. Primary beneficiaries, those individuals specificially entitled by law to direct care in facilities of a particular providing agency, would not be adversely affected. The bill establishes a Federal Interagency Medical Resources Committee composed of the Secretary of Defense and the Administrator of Veterans' Affairs or their designees for the purpose of estabilshing policy relative to interagency sharing to include: (1) identification of opportunities to maximize the sharing of both existing and planned medical resources; (2) establishment and monitoring procedures for coordinated planning; (3) prescribing uniform guidelines within 180 days of the bill's enactment providing for, (a) sharing arrangements whenever possible to cover all beneficiaries authorized direct care by a providing facility of the other agency, (b) sharing of any medical resource, (c) negotiation of resources to be shared by commanders/directors of facilities, (d) referral of beneficiaries to facilities of another agency, which shall not, as determined by participating agency officials interfere with the quality of care and priority of access to medical services to beneficiaries of the providing agency, (e) reimbursement based on negotiated costs between heads of participating facilities, (f) reimbursement to be credited to the specific facility providing the services, and (g) sharing arrangements to be operative upon agreement of facility directors/commanding officers unless disapproved upon submission to each agency.

The bill instructs the Federal Resources Sharing Committee not to alter existing agency responsibility regarding provision of medical services provided by law. Finally, the bill requires the Committee to submit a report to the Congress within 1 year of enactment and subsequently on an annual basis addressing prescribed guidelines, opportunities for sharing, sharing arrangements concluded, and other interagency efforts to improve planning utilization and coordination of Federal Health resources.

We strongly support the objectives of S. 266, but recommend that certain modifications be made in the bill. Our specific comments are provided below:

> Title: We recommend that the purpose of the bill, that is, "To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources" be changed to read, "To ensure the development and implementation of policies and procedures to encourage the Veterans' Administration and the Department of Defense to cooperate in the efficient and effective use of Federal medical resources, and for other purposes." We feel that this change expresses in a more comprehensive manner, the legislative intent behind this proposal.
>
> Sec. 3(5). We believe that the definition "negotiated cost" is a complex issue and should identify for local hospital officials the principal cost elements to be included. Alternatively, the Federal Interagency Health Resources Committee could develop such guidelines.
>
> Sec. 4(a)(7). We recommend that the guidelines required to be prescribed by the Interagency Committee be subject to ratification by each of the agency heads involved and that this section should so specify.
>
> Sec. 4(a)(7)(F). We are concerned that this provision might be interpreted as requiring the earmarking of collections down to the level of specific units within a sharing facility. Such a requirement is unnecessary and would be administratively burdensome. Accordingly, we suggest that the language be amended to read: "Amounts collected shall be distributed to the facility that generated the reimbursement."

Subject to the changes noted above, we would favor enactment of S. 266.

COST AND BUDGET DATA

The cost of the proposed legislation cannot at this time be estimated by the Department of Defense, however, it would not be expected to result in a significant additional resource requirement, and savings as yet undetermined are expected to result from better utilization of Federal medical resources.

The Office of Management and Budget advises that from the standpoint of the Administration's program, there would be no objection to the presentation of this report for the consideration of the Committee.

Sincerely,

William H. Taft, IV.

[No. 49]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., August 12, 1981.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: We are pleased to respond to your request for the views of the VA on S. 266, a bill "To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources."

S. 266 is intended to clarify, and to some extent enlarge upon the authority of the Veterans' Administration (VA) and the Department of Defense (DoD) to share medical resources and thereby facilitate and encourage the interagency sharing of medical care and medical care support resources. With changes to address concerns we have identified, the VA would support enactment of S. 266.

The bill would establish a Federal Interagency Medical Resources Committee, to be composed of the Secretary of Defense and the VA Administrator. The bill provides for such Committee to undertake a series of actions with a view to establishing policies applicable to both the VA and DoD with regard to the interagency sharing of medical resources. Thus, such Committee would undertake: To assess opportunities for sharing Federal health resources; to include the potential for sharing in planning for additional VA or DoD medical facilities and acquisition of major new medical equipment; to identify sharing opportunities that would not adversely affect the quality or priority of care provided; and to prescribe policies and procedures to maximize VA and DoD sharing. This 2-member Committee would also be charged with coordinating the establishment and monitoring the implementation of uniform interagency health-care policies and procedures, including coordinated planning for future development of each agency's direct health-care delivery system. In connection with these various duties, the bill also provides that the 2-member Committee shall consult, when appropriate, with other Federal providers to encourage optimum coordination in the delivery of direct health care.

The bill would also require that the Committee prescribe uniform guidelines to commanding officers and directors of each VA and DoD health-care facility for the sharing of medical resources by such health-care facilities with each other. Under those guidelines such facility heads would be mandated to enter into interagency sharing agreements whenever possible. Under such arrangements, primary direct health-care beneficiaries of either the VA or DoD could receive medical care at both VA and DoD facilities. The scope of services subject to sharing could include any medical care or medical care support resources.

The bill provides that the availability of direct health care both to VA beneficiaries at DoD facilities and to DoD beneficiaries at VA facilities would be on a referral basis. Facility directors who would negotiate such arrangements would have to determine that any such arrangements would not adversely affect the quality of care and the priority access for medical services of the providing agency's beneficiaries. Reimbursement, to be based on a determination of costs negotiated by the heads of the participating VA and DoD facilities, would be credited to the specific provider facility. Sharing arrangements would become operative upon agreement between facility managers, subject to disapproval by agency headquarters.

The bill includes caveats to the effect that the proposed joint responsibilities of the Commitee as to uniform direct health care should not be construed to alter the individual agencies' statutory responsibilities with regard to providing medical services, and that it would not preclude the sharing of medical resources under any other law among all Federal providers.

Last, S. 266 contains a requirement for the proposed Committee to prepare an annual report to be submitted to the Congress as a whole with regard to specific aspects of implementation, including legislative recommendations, and to the House and Senate Appropriations Committees annually thereafter when presenting the applicable agency's appropriations request each fiscal year.

Congress had the foresight to recognize the utility of the sharing concept for the VA medical care system in the early 1960's. Public Law 89–785, enacted in November 1966, gave the Veterans' Administration specific statutory authority to enter into agreements to receive from and share with medical schools, hospitals, and research centers throughout the country the most advanced medical technology, information, and certain specialized medical resources. This authority was intended to improve the quality of hospital care and other medical services provided veterans by authorizing the Administrator to receive and share specialized medical resources without diminution of services to veterans. Congress also had given the Secretaries of the military departments and the VA Administrator authority, with some exceptions, to enter agreements for the mutual use or exchange of use of hospital and domiciliary facilities, equipment and supplies, and for the transfer among them of these items without reimbursement (38 U.S.C. §5011), but this authority was seldom if ever invoked.

Veterans' Administration sharing activity has grown dramatically. The number of sharing contracts has increased 15 times since enactment of sharing authority 14 years ago. In 1967, only 15 VA hospitals had agreements to share specialized medical resources under section 5053 of title 38, United States Code; those 15 agreements had a total monetary value of services bought and sold of $118,875. In 1979, there were 99 VA medical centers having 240 sharing contracts for a total value of services exchanged amounting to $20,198,677. Sharing has been beneficial not only to the VA, but to the community as well. Additionally, new items and new services have been added each year since this sharing law was enacted. The sharing agreements have resulted in better cooperation between VA hospitals and their community counterparts, and in better utilization of medical specialists, technologies and facilities.

Together with our sharing efforts with community facilities, VA has enthusiastically sought increased cooperation among Federal medical systems. The VA has for many years been in the forefront among Federal agencies in initiating "cross-servicing" agreements under the Economy Act. The VA currently has 64 active field facility cross-servicing medical service and research agreements, 23 such agreements between VA Central Office and other Federal agency headquarters, and 18 active agreements to procure medical supplies with other Federal agencies in the interest of economy. These Veterans' Administration agreements involve other Federal agencies such as the Departments of Health and Human Services, Defense, Justice, and Energy, and the Office of Personnel Management, NASA, and the Federal Aviation Administration. We believe our extensive activities in this area evidence our commitment to the sharing of Federal medical resources, thereby facilitating medical care cost efficiency.

As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases to insufficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle. We believe that adoption of a policy directing that amounts collected be distributed to the facility that generated the reimbursement would be helpful.

Our own specific sharing authority in section 5053 of title 38, United States Code, is limited in scope to specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

In addition, the VA has played an important role in developing greater coordination in health services planning by Federal agencies through its role on the Federal Health Resources Sharing Committee. Initial interagency meetings in August and September 1977 to explore joint Federal planning and sharing of specialized medical resources culminated in the formal establishment of the Federal Health Resources Sharing Committee in February 1978. The committee (FHRSC), whose members represent the Air Force, Army, Navy, DoD, Public Health Service and the VA, has met more than 15 times.

In order to respond effectively to the findings and recommendations of the Congress, OMB and GAO, the Committee has to date established six subcommittees. They have made progress in developing guidelines and criteria for assessing, and justifying the need for, and appropriate location of, particular specialized medical services, in developing program utilization standards, and in actively exploring sharing opportunities in specific geographic areas.

The VA strongly supports the goal of achieving increased interagency cooperation in the use of Federal medical resources. We also applaud the development of incentives to increase sharing, particularly the bill's provision that would credit reimbursement to the specific facility which provided the medical service. The proposed legislation represents one means of encouraging an important goal.

Congress has charged the VA with providing a broad array of medical services to care for and treat veterans suffering from service-incurred and other disabilities. The VA health-care system represents a commitment to the promise of quality care for veterans. In reviewing the proposed Federal Interagency Medical Resources Sharing and Coordination Act of 1981, we must consider whether this proposed attempt to achieve improved efficiency and economy would also serve the veteran, or conversely whether it would damage the system upon which the veteran has relied, and deprive the veteran of promised quality VA care.

Central to achieving a health-care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. S. 266 reflects a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DoD have to their primary beneficiaries. In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

While the VA has long provided needed medical care or resources for active duty military members, neither our facilities nor our mission were designed to furnish health-care services to military dependents. S. 266 could mandate such care under its broad definition of the term "beneficiary." We believe inclusion of military dependents within S. 266 is inappropriate, and opening the VA health-care system to these DoD beneficiaries is ill advised.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. We would welcome the opportunity to build on and expand such sharing through incentives.

While we have focused primarily on the very broad issues raised by this bill, we have several concerns which should not escape attention. One is the provision that would appear to make sharing arrangements operative upon agreement by facility directors, subject only to subsequent revocation after submission to agency headquarters. We believe this provision may not allow sufficient review at the Department or Central Office level which we consider essential in light of the potential magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself. We have made considerable progress in streamlining the process of reviewing sharing agreements and do not believe such provision in the bill is prudent or needed.

Secondly, we recommend that the legislative history should make clear that the uniform policies and procedures required by section 4(a)(4) and section 4(a)(5) of the bill to be prescribed by the 2-member committee jointly should be subject to ratification by each of the agency heads involved. Similarly, we believe that the uniform guidelines to be prescribed by the Committee under section 4(a)(7) should likewise be subject to ratification by each of the agency heads involved.

As regards your [illegible] for our etsimate of the 5-year fiscal costs (or savings) which would result from enactment of S. 266, it is extremely difficult to make any overall meaningful estimate. Any such estimate would depend on such uncertainties as the number of sharing arrangements effected, the extent and cost of the medical resources shared in relation to their anticipated cost in the open market, and on the extent to which future sharing arrangements during the 5-year period should be attributed to enactment of S. 266 rather than to existing sharing authorities.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

ROBERT P. NIMMO,
Administrator.

Enclosure.

[No. 52]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., August 12, 1981.

Hon. Alan K. Simpson,
Chairman, Committee on Veteran's Affairs,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of June 9, 1981, for the views of this Office on S. 266, a bill "To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources."

In reports to your committee, the Department of Defense and the Veterans' Administration indicate their support of S. 266, subject to certain modifications. We concur with the views expressed by the Department of Defense and the Veterans' Administration in their reports, but would suggest one further modification.

With respect to section 4(a) (7) (F), we agree with the Department of Defense that this provision might be interpreted as requiring the earmarking of collections down to the level of specific units within a sharing facility, and that such a requirement is unnecessary and would be administratively burdensome. The Department has suggested that the language be amended to read: "Amounts collected shall be distributed to the facility that generated the reimbursement."

We recognize the desirability of providing an incentive for facilities to enter into sharing arrangements by providing for reimbursement to the individual facility, and would expect this to be the general practice if legislation along the lines of S. 266 is enacted. Nevertheless, we believe the law should allow for some flexibility for those cases in which total reimbursement to the individual facility might not be judged appropriate for the most effective management of the resources of the two agencies. Accordingly, we would suggest adding "to the maximum extent feasible" to the revised language proposed for section 4(a) (7) (F) by the Defense Department.

Subject to the foregoing, we would support enactment of S. 266.

Sincerely,

James M. Frey,
Assistant Director for
Legislative Reference.

AMENDMENT NO. 62

Purpose: To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense.

IN THE SENATE OF THE UNITED STATES—97th Cong., 1st Sess.

S. 636

To clarify the Veterans' Administration's authority to recover certain health-care costs, to extend the period of availability of funds committed under the Veterans' Administration program of assistance to new State medical schools, to authorize expansion of the scope of an epidemiological study regarding veterans exposed to Agent Orange, and for other purposes.

June 9 (legislative day, June 1), 1981

Referred to the Committee on Veterans' Affairs and ordered to be printed

AMENDMENT intended to be proposed by Mr. CRANSTON

Viz: Add at the end of the bill the following new section.

SEC. 5. (a) This section may be cited as the "Veterans' Administration and Department of Defense Medical Sharing Act".

(b) Section 5011 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "The Administrator";

(2) by striking out "or for the transfer" and all that follows through "care for veterans,";

(3) by striking out "and domiciliary beds below the number established or approved on June 22, 1944" and inserting in lieu thereof ", domiciliary, and nursing home beds below the number established or approved under section 5010 of this title"; and

(4) by adding at the end the following:

"(b)(1) It is the sense of the Congress that there are opportunities for greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense which, if achieved, would be beneficial to both veterans and to members of the Armed Forces on active duty and which could result in reduced costs to the Government. Accordingly, the Administrator and the Secretary of Defense shall direct that the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, respectively, form an interagency committee to maintain oversight of opportunities for sharing of medical resources of the Veterans' Administration and the Department of Defense and to make recommendations to the heads of their respective agencies with respect to the sharing of those medical resources.

"(2) In addition to such other duties as may be assigned to them in order to carry out this subsection, the Chief Medical Director and the Assistant Secretary of Defense for

Health Affairs (hereinafter in this section referred to as the 'Assistant Secretary') shall regularly—

"(A) assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;

"(B) keep the other apprised of plans for any additional medical facilities planned by their respective agencies (including the location of new facilities and the acquisition of major new medical equipment) with regard to the impact of such plans on opportunities for interagency sharing;

"(C) review the existing capabilities of the Veterans' Administration and of the Department of Defense with respect to direct health care (including support and administrative services) in order to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either the Veterans' Administration or the Department of Defense; and

"(D) recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of the medical resources of the Veterans' Administration and the Department of Defense.

"(3) In carrying out the duties prescribed by this subsection, the Assistant Secretary shall consult regularly with the Surgeons General of the Army, Navy, and Air Force.

"(4) The Chief Medical Director and the Assistant Secretary may each carry out their respective functions under this subsection through any other official designated for such purpose.

"(c) Not later than one year after the date of the enactment of this subsection, and after considering the recommendations of the Chief Medical Director and the Assistant Secretary submitted under subsection (b) of this section, the Administrator of Veterans' Affairs and the Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. Such guidelines shall include provisions for the following:

"(1) The director, in the case of a health care facility of the Veterans' Administration, or the medical or dental officer in charge, or the contract surgeon in charge, in the case of a health care facility under the jurisdiction of the Department of Defense may enter into cooperative sharing agreements with health care facilities of the other agency. Under any such agreement, an individual entitled to direct health care in a facility of one agency may be provided medical care at the facility of the other agency.

"(2) Each agreement entered into pursuant to paragraph (1) of this subsection between the head of a facility of the Veterans' Administration and the head of a facility of the Department of Defense shall explicitly define the health care to be provided pursuant to such agreement. Services to be shared may include any medical resource, but the resources to be shared shall be negotiated and agreed upon by the heads of the facilities entering into the agreement.

"(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the range of services, quality of care, or priority access for services of the primary beneficiaries of the providing agency.

"(d)(1) Whenever a beneficiary receives medical services from a providing agency other than the providing agency for which such beneficiary is a primary beneficiary, the providing agency shall be reimbursed for the cost of the services provided based on any costing methodology agreed upon by the

Administrator and the Secretary of Defense that is based on the cost of the services provided.

"(2) Any reimbursement under paragraph (1) of this subsection shall be credited to the appropriation and to the facility that provided the services.

"(e) The Administrator and the Secretary of Defense shall submit an annual joint report to Congress, to be submitted at the time the President's Budget for the next fiscal year is transmitted, with regard to—

"(1) the guidelines prescribed pursuant to subsection (c) of this section;

"(2) the opportunities for interagency sharing determined under subsection (b)(2) of this section;

"(3) the interagency sharing agreements entered into by health-care facilities of the Veterans' Administration and the Department of Defense;

"(4) the activities of the Veterans' Administration and the Department of Defense under such interagency sharing agreements;

"(5) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

"(6) the progress of Federal interagency medical resource sharing during the preceding fiscal year;

"(7) the interagency coordination of Federal health resources planning;

"(8) other major Federal activities to increase interagency sharing of Federal medical resources; and

"(9) such legislative recommendations as they consider appropriate to facilitate interagency sharing of health care resources.

"(f) For the purposes of this section:

"(1) The term 'direct health care' means health care provided to a beneficiary in a facility operated by the United States Government.

"(2) The term 'beneficiary' means a veteran who is entitled under this title to health care in Veterans' Administration facilities or a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

"(3) The term 'providing agency' means the Veterans' Administration or the Department of Defense.

"(4) The term 'primary beneficiary', with respect to the Veterans' Administration, means a veteran who is entitled under this title to health care in Veterans' Administration facilities, and, with respect to the Department of Defense, means a member or former member of the Army, Navy, Air Force, or Marine

Corps who is entitled to medical and dental care under section 1074 of title 10.

"(5) The term 'medical resource' means medical care resources and medical care support resources.

"(g)(1) Notwithstanding any other provision of this title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, as authorized by this section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

"(2)(A) The Administrator may contract with private facilities for the provision by such facilities of hospital care and medical service described in subparagraph (B) of this paragraph during a period described in paragraph (1) of this subsection in which the President has authorized the Veterans' Administration to furnish priority medical care and services to members of the Armed Forces on active duty.

"(B) Hospital care and medical services referred to in subparagraph (A) of this paragraph are—

"(i) hospital care needed to treat a condition for which a veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition; and

"(ii) hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care or services under chapter 17 of this title, if Veterans' Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under paragraph (1) of this subsection.

"(C) The Administrator shall prescribe regulations to govern contracting under this paragraph.

"(D) The authority of the Administrator to enter into contracts under this paragraph is subject to the availability of appropriations for that purpose.

"(3) The cost of any care or service provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense and are based on the cost of the care or service provided.

Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided the care or service.

"(4) The Administrator and the Secretary of Defense may, without further review of such requests within the executive branch, submit requests to Congress (A) for relief from applicable personnel ceilings or other administrative restrictions, when such relief is needed in order to carry out this subsection, or (B) for appropriations to carry out this subsection.

"(5) Within 30 days after an authorization by the President under paragraph (1) of this subsection for the Veterans' Administration to provide priority hospital care and services to members of the Armed Forces on active duty (or as soon after the end of such thirty-day period as is reasonably practicable), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report of the Administrator's plan for the allocation of facilities and personnel in order to provide such care and services.

"(6) During a period of war or national emergency described in paragraph (1) of this subsection, the Secretary of the military department concerned, upon the recommendation of the Administrator, may relieve any officer or employee of the Veterans' Administration whose duties concern the furnishing of care and services under chapter 17 of this title from any obligation to perform active military service which such officer or employee would otherwise be required to perform.".

(c)(1) The heading of such section is amended to read as follows:

"§5011. Sharing of Veterans' Administration and Armed Forces facilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5011. Sharing of Veterans' Administration and Armed Forces facilities.".

(d) The Administrator of Veterans' Affairs shall enter into an agreement with the Secretary of Defense not later than one hundred and eighty days after the date of the enactment of this Act under which the Administrator and the Secretary shall agree to pursue planning activities and to establish procedures and guidelines under which subsection (g) of section 5011 of title 38, United States Code, as added by subsection (b), may be carried out.

[From the Congressional Record, Vol. 127, No. 86, pp. S5942-S5944—Senate, June 9, 1981]

VETERANS' ADMINISTRATION/DEPARTMENT OF DEFENSE SHARING OF MEDICAL FACILITIES

Mr. **CRANSTON**. Mr. President, I am today submitting, for appropriate reference, an amendment to S. 636, a VA health-care measure pending in the Veterans' Affairs Committee. The legislation in the amendment would be cited as the "Veterans' Administration and Department of Defense Medical Sharing Act."

This measure, which is substantively identical to a measure reported by the House Committee on Veterans' Affairs on May 19, 1981, addresses two distinct but interrelated issues involving the health-care resources of the Veterans' Administration and the Department of Defense: First, the potential for greater sharing of these resources during peacetime so as to yield increased efficiency in the Federal health-care sector, while continuing to recognize and respect the separate missions of the two agencies; and, second, the appropriate role for the VA's health-care system as a back-up to the medical resources of the Department of Defense in the event of armed conflict when U.S. military casualties might overwhelm DOD's ability to provide the needed care.

Mr. President, the Committee on Veterans' Affairs has a hearing scheduled for June 17 on the issues addressed by this measure, and a bill, S. 266, that was introduced by my good friend, the Senator from Illinois (Mr. Percy), and deals with the first of the two issues I mentioned above—the sharing of resources during peacetime—will be before the committee at that time. I also understand that another measure, dealing with the appropriate wartime relationship between VA and DOD may be introduced shortly for committee consideration at that hearing.

I am submitting this measure today because, unlike S. 266 and what I understand of the other measure that may be introduced shortly, it proposed changes to title 38 of the United States Code, the codified U.S. statutes dealing with veterans' benefits and the VA. I believe that this is the appropriate place to locate the type of changes contemplated by the various measures, and I therefore want the committee to have a full opportunity to consider this approach and the proposals in the House-reported bill at its upcoming hearing, and at the markup meeting scheduled for June 25.

Mr. President, I want to note that, in submitting this measure today, I am not taking a position on any of the many questions related to the two VA-DOD sharing issues, including the most fundamental issue of whether there is even a need for further legislation in these areas or whether, alternatively, what is needed here is greater flexibility on the part of the two agencies in their dealing with one another. I intend to consider very carefully the views of all witnesses at the June 17 hearing, as well as those of any other interested parties, on these issues.

Mr. President, I ask unanimous consent that the text of the amendment be printed in the Record.

There being no objection, the amendment was ordered to be printed in the Record, as follows:

* * * * * * *

[No. 53]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., September 15, 1981.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to your request for the views of the VA on Amendment No. 62 to S. 636, 97th Congress. The purpose of this amendment is "To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense." Amendment 62 is identical to H.R. 3502, which was referred jointly in the House of Representatives to the Committees on Armed Services and Veterans' Affairs.

The major purpose of this amendment is to encourage and assist greater sharing of medical resources between the VA and the Department of Defense in order to benefit the primary beneficiaries of both agencies and which could result in reduced costs to the government. At the same time, it would also create a priority for care for active duty armed forces members in time of war or national emergency second only to the priority for service-connected veterans for care and treatment. Subject to several revisions discussed below, the VA favors the enactment of the provisions of this amendment.

Amendment 62 would mandate that the Secretary of Defense and the Administrator of Veterans' Affairs direct the Assistant Secretary of Defense for Health Affairs and the Chief Medical Director respectively to form an interagency committee to assess jointly opportunities for sharing health resources between the VA and the DOD, to keep each other apprised of plans for establishing additional VA or DOD medical facilities and for the acquisition of major new medical equipment, and to identify sharing opportunities that will not adversely affect the quality or priority of care provided. This amendment would further require the two officials to recommend to their respective agency heads policies and procedures to maximize VA and DOD sharing of medical resources. In connection with these various duties, the amendment would also require that the Assistant Secretary of Defense for Health Affairs consult regularly with the Surgeons General of the Army, Navy and Air Force.

Amendment 62 would mandate that the Administrator of Veterans' Affairs and the Secretary of Defense within a year of its enactment jointly establish guidelines for the sharing of medical resources between VA and DOD medical facilities. These guidelines would authorize VA and DOD health-care facility directors to enter into cooperative sharing agreements whenever possible.

Under the guidelines, these agreements would be negotiated between the heads of the facilities concerned and would explicitly define the health care to be provided under the agreement. Under the amendment's definitions, both veterans entitled to care in VA facilities and members and former members of the Army, Navy, Air Force or Marine Corps entitled to medical and dental care under title 10, United States Code, would be considered "primary beneficiaries of the respective agencies," and as such could be provided medical care under a sharing agreement.

The agreements would have to assure that the availability of direct health care for such beneficiaries be on a referral basis only, and that any such care rendered nonprimary beneficiaries would not adversely affect the range of services, quality of care, or priority access for service of the providing agency's primary beneficiaries. Reimbursement of the providing facility's costs, using any costing methodology based on the cost of the service provided, would be as agreed on by the Secretary of Defense and VA Administrator, and would be credited to the specific facility which provided the health care services.

The measure also calls for a VA–DOD annual joint report with regard to various aspects of the bill's implementation, to be submitted to the Congress as a whole at the time the President's Budget for the next fiscal year is transmitted.

Although the amendment does not specifically so provide, it appears clear that the proposed joint responsibility of the Secretary of Defense and Administrator of Veterans' Affairs as to uniform direct health care is neither intended to alter VA's or DOD's statutory responsibility with regard to providing medical services, nor to preclude the sharing of medical resources under any other law, except to the extent that it would amend 38 U.S.C. § 5011 to eliminate the authority of both the VA and the military department heads to transfer to the other "facilities, supplies equipment or material" needed in the care of veterans without reimbursement of appropriations.

The VA is strongly committed to the concept of sharing and to the particular benefits of increased interagency sharing of medical resources between VA and DOD facilities. As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases, to inefficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

The Agency believes that distributing the amounts collected to the facility that generated the reimbursement would be helpful. The VA has specific authority in section 5053 of title 38, United States Code, to share specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

The Agency finds the interagency sharing provisions of Amendment 62 to be workable and sensitive to the needs of the VA, creating highly desirable incentives to *encourage* such sharing.

Central to achieving a health-care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The interagency sharing provisions of Amendment 62 in our judgment, reflect a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DOD have to their primary beneficiaries. In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. The VA would welcome the opportunity to build on and expand such sharing through the incentives that the interagency sharing authority in the bill would provide. In sum, the VA believes the language of that measure would satisfy the needs of both agencies and encourage and facilitate increased interagency sharing of medical resources between the Veterans' Administration and the Department of Defense. The provisions would also maintain the integrity and separate health-care missions of these provider agencies, and enhance their respective abilities to accomplish these missions in a cost-effective manner.

The VA has long provided needed medical care or resources for active duty military members, but neither our facilities nor our mission wre designed to furnish general health-care services to military dependents. While the VA could, under existing authority, furnish scarce medical services to any DOD beneficiary under a sharing agreement, we would oppose any proposal which would open the VA health-care system at large to military dependents.

In essence, VA supports enactment of the sharing provisions of Amendment 62 so long as any such legislation does not extend VA medical services to military dependents. Enactment of those provisions would not result in any costs to the VA.

Amendment 62 would also formalize the role the Veterans' Administration might play in planning and providing actual support for the Department of Defense in time of war or national emergency. This measure would establish a special priority for VA hospital care, nursing home care, and medical services for members of the Armed Forces on active duty during a period of war or a period of national emergency declared either by the President or the Congress. This priority would be second only to the priority of service-connected veterans for care and treatment.

It would also provide special contract authority during such a period of war or national emergency to permit the Administrator to furnish (1) hospital care for veterans currently receiving outpatient medical services under subsections (f) and (g) of section 612 of title 38, United States Code, if delay in furnishing such hospital care would be likely to result in deterioration of the veteran's condition, and (2) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing the care or services required because of furnishing care to members of the Armed Forces under this new authority.

Amendment 62 would provide for DOD reimbursement to the VA at rates agreed upon by the Administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursements to the VA would be credited to the appropriations available to the VA facility providing the care or service. The measure also makes provision for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable), to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

The measure would also direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

The contingency medical backup of the VA to the military medical system has been of historic importance. It has, however, generally involved the acceptance of military personnel recently separated for medical disabilities. Others have been accepted on a space-available basis and returned to duty status.

The military medical system currently has a manifest need for increased combat casualty support. This provision is designed to formalize the VA's contingency mission by upgrading the priority for VA care of the active duty casualty and giving VA flexibility to enter into long-range plans with DOD to furnish various levels of support.

The VA strongly supports the desirability of medical contingency planning between the Department of Defense and this Agency. Requirements in the law that VA facilities be maintained to ensure their availability for the treatment of the veteran, and that preference in providing medical services be given to various classes of veterans have, however, prevented us from committing the Agency to specific plans for participation in a civilian-military contingency hospital system.

Interagency agreements were signed with DOD in 1965 and with DHEW (DHHS) in 1972 to coordinate planning and mutual support roles. The agreement with DOD established policies and directed planning to utilize VA facilities for military patients in support of a national emergency when the United States is not under attack. The agreement with DHEW was designed to ensure the maximum utilization of VA health resources *following an attack* "upon the United

States" and to facilitate developing joint emergency operating plans and procedures.

Within the last 2 years, efforts have been made to review and update these two agreements and to establish operating procedures and coordinating systems. The need for this action has been made apparent in recent joint military civilian readiness exercises sponsored by the Federal Emergency Management Agency (FEMA).

While the VA has embarked on preliminary discussions with DOD to determine how our resources could best be utilized in a support role, we believe that legislation such as Amendment 62 would be needed to assure that VA could provide meaningful support to the Department.

Providing priority care to military personnel under such a contingency would necessarily displace certain eligible nonservice-connected veterans temporarily from access to care at VA medical centers involved in this effort. Although the VA does not favor the denial of care to any eligible veteran at any time, Amendment 62 draws a reasonable line in providing the agency contract authority to assure continuity of care for those veterans under treatment and for others in need of emergency care. We believe that the limited exercise of this contract authority would be justified during a period of war or national emergency. The Agency believes military casualties should have a high priority claim on the limited VA resources that could be available at such a time. Accordingly, we believe special contract authority would permit the agency to respond flexibly in such an emergency situation.

The proposed new section 5011(g)(1) would empower the President to authorize the Administrator to extend higher priority for treatment to "members of the Armed Forces on active duty" than to other eligibles except veterans with service-connected disabilities. We understand this broader language to reflect an intention to leave to the Administrator and Secretary of Defense determinations as to the kinds of medical cases to be referred to the VA. Such determinations would be addressed in detailed guidelines to be developed under this proposal.

While we favor legislation to meet the purposes of Amendment 62, we oppose the following two provisions and urge their deletion. We strongly oppose proposed new section 5011(g)(4), which would authorize, without executive branch review, requests to Congress for relief from personnel ceilings or for appropriations to carry out this emergency authority. That proposal represents an unwarranted intrusion into the prerogatives of the President and the executive branch. This Administration and any Administration would request on a swift and timely basis any additional funds or personnel necessary to meet emergency requirements. We also oppose the provision which would authorize the Secretary of the military department concerned, during the period of war or national emergency, to relieve VA employees whose duties concern the furnishing of care and services under chapter 17 of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform.

Enactment of the provisions of Amendment 62 would not result in any immediate costs to the VA. Planning and testing associated with this proposal would require no additional resources, and the costs of activating the contingency system cannot be projected with any reliability until the need for those services arises.

The Office of Management and Budget has advised that there is no objection to the presentation of this report and that enactment of proposed new section 5011(g)(4) would not be in accord with the President's program.

Sincerely,

DONALD L. CUSTIS, M.D.
(For Robert P. Nimmo, Administrator).

[No. 54]

COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE

FEDERAL EMERGENCY MANAGEMENT AGENCY,
Washington, D.C, September 24, 1981.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This replies to a request for comment on a proposed amendment, in the nature of a substitute, for S. 636.

Except for subsection (g) dealing with the national emergency period, we defer to the views of the Department of Defense (DOD) and the Veterans Administration (VA).

We do not have any basis on which to estimate the fiscal cost of this amendment, and defer to DOD and VA on that matter.

With respect to subparagraph (g)(4), we consider the proposal to circumvent the established executive branch procedures for budget and program reviews as an unwarranted incursion into the prerogatives of the executive branch and strongly object to this provision.

We also oppose the provision relieving VA personnel from any military service obligation, thus creating a privileged group. Such a measure would create a precedent and compromise the random selection policy which would be applicable to any military draft as well as contravene the existing no-deferment policy for members of the Ready Reserve.

The Office of Management and Budget advises that there is no objection to the submission of this report and that enactment of section 5011(g)(4) of Amendment No. 62 to S. 636 would not be in accord with the President's program.

Sincerely,

WILLIAM L. HARDING
(for George Jett, General Counsel.)

Senator MURKOWSKI. Before hearing statements from other members of this committee, we are privileged to have with us Senator Percy, who introduced Senate bill 266, the Federal Interagency Medical Resources Sharing and Coordination Act of 1981. His Committee on Governmental Affairs has completed work on this bill and referred it to us for consideration.

Senator Percy, we are pleased to have you with us this morning, and welcome to the committee.

STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator PERCY. Mr. Chairman, I want to thank you for your courtesy in giving me the opportunity to testify this morning. My statement will be relatively brief.

Taking into account the President's comments last night about action by the House on the make-believe budget cuts that they have conjured up, I think we ought to just make notice of the fact that the Government Affairs Committee voted out the Federal Interagency Medical Resources Sharing and Coordination Act of 1980 last year. It was passed unanimously by the Senate. It was estimated by Elmer Statts, Comptroller General of the United States, that the savings would be as much as a quarter of a billion dollars a year from this commonsense approach of sharing facilities.

We have now thrown away a quarter of a billion dollars by the inaction of the House. The House this year is acting on the bill, but the committee in the House has reported out a bill with three amendments. They were urged by the Veterans' Administration, and two of the amendments are crippling. I will discuss those at the end of my statement. Mr. Chairman, I'm very sorry, I must chair a hearing at 10 o'clock, so I'll be as brief as I can.

One of the amendments is perfectly acceptable. The other two are totally unacceptable, and I hope will be opposed by this committee. They are resisted by the Department of Defense, and they are resisted by the Comptroller General, GAO, and other witnesses that appeared before us last year.

I think in general one of the most important responsibilities of our National Government is to care for the many veterans who have given so much to their country. While the VA hospital system gets more than its share of criticism, I think it's done an admirable job, in taking care of those who have nowhere else to turn for help.

Through the fine efforts of this committee and others, I am confident this tradition will continue.

The Federal Government also has a responsibility to spend the taxpayers' money with the utmost care and efficiency. The legislation before this committee, the Federal Interagency Resource Sharing and Coordination Act of 1981, will save the taxpayer millions of dollars, estimated at about a quarter of a billion a year, while actually enhancing the care of veterans and other Federal beneficiaries. This is a rare bill, then, in these days of budget slashing. It saves money and strengthens important Federal programs. Greater sharing of existing and new medical resources will improve access to medical care, reduce the cost of providing this care, and enhance the quality of medical services provided by the Federal Government.

The reason for the bill came up when, very near to my home, in Illinois, we had a request for $25 million from the Veterans' Administration to renovate a VA hospital facility, when within practically walking distance was a modern Navy facility with 450 empty beds. While there was excess room available in the naval facility, you had a Veterans' Administration hospital less than a mile away asking for $25 million. It just didn't make any sense to me. And I found that there was no basis for sharing facilities between Government agencies. It's the same taxpayer who is paying those bills. That is what brought the research and this bill forward.

When I began looking at the Veterans' Administration and Defense Department hospital programs, I was shocked to discover that expensive medical equipment was being acquired, physicians were being hired, and hospitals were under construction with little regard for how these resources might be shared or coordinated among the two agencies. Even worse, I was told that attempts by local VA and Defense hospital officials to share services had stalled due to restrictive regulations, lack of guidance in Washington, and legal roadblocks.

The General Accounting Office and the Committee on Government Affairs have documented dozens of examples of untapped opportunities for greater cross-agency sharing. As I mentioned, one of the most startling was the Great Lakes Naval Hospital that sits three-quarters empty because of a serious doctor shortage. The Navy facility has been forced to spend $3 million a year on private physicians to fill some medical specialties, yet some services remain unavailable. Less than 1 mile away, in North Chicago, Ill., there's an aging VA hospital that will need millions of dollars for improvement over the next 5 years.

The VA facility has a relative abundance of doctors. So far, all attempts at sharing the resources of the two facilities have failed because of restrictive laws and regulations.

Some have feared that any sharing between the VA and Defense Department would only benefit the Defense Department, since its medical program is much smaller than the VA's. This is simply not so.

The 1978 General Accounting Office report on interagency sharing documented many opportunities for sharing that would have benefited veterans. In the Key West area, for example, a Navy hospital with 19 doctors had an average patient occupancy rate of only 19 patients. In spite of this obvious underutilization, veterans needing medical care who lived near Key West were forced to drive 160 miles to the Miami Veterans Hospital for lack of any cross-agency coordination. The Navy claimed that regulations barred any sharing with the VA.

Last July, the Senate Government Affairs Committee held hearings on legislation nearly identical to S. 266. The reaction to the bill was nearly unanimous in support of the sharing legislation.

Subsequent to the hearings, the committee worked closely with the VA, Defense Department, GAO and Federal Health Resources Sharing Committee, OMB and other interested parties, to further improve and strengthen the legislation.

For example, safeguards were added which prohibit sharing that would have a detrimental effect on the quality of care of any Federal beneficiaries. I can say without hesitation that S. 266 has been as carefully drafted to represent all interests as any legislation I have been associated with.

As you know, the House Veterans' Affairs Committee has reported similar legislation. The House version, H.R. 3502, closely parallels S. 266, except with respect to three issues. I'd like to comment briefly on each.

First, the House Veterans' Affairs Committee report on H.R. 3502 specifically prohibits the Veterans' Administration from treating military dependents under any conditions. S. 266 allows any beneficiary of either agency to be treated by the other on a referral basis as long as certain conditions are met.

The purpose of S. 266 is to knock down restrictive regulations and statutes which preclude sharing that would be beneficial to both the taxpayer and patient.

While I understand that in many cases the VA is not equipped to treat military dependents on an inpatient basis, witnesses at our hearings last July have testified that there are some medical services that could be shared, and, in fact are being shared, with dependents, without any adverse effect on veteran patients.

For example, there is no reason why a military dependent could not have an X-ray taken or get a laboratory test done at a VA hospital. In the Veterans' Administration comments on S. 266 they state that, "While the VA has long provided needed medical care for active duty military members, neither our facilities nor our mission were designed to furnish health care services to military dependents."

It is ironic that while the VA professes to be unable to provide services to military dependents, in the same comments, they point out that they have eagerly implemented $20 million worth of sharing arrangements with community hospitals across the United States, arrangements which they say have resulted in better cooperation with these communities.

H.R. 3502 also differs from S. 266 with regard to the rates for reimbursement between agencies. H.R. 3502 provides for standard rates for medical services to be established, whereas S. 266 allows for local officials to negotiate rates that are agreeable to all parties.

The GAO and local hospital administrators testified last year that one of the major disincentives to interagency sharing is the existence of standard rates for services. Often these rates do not represent the true cost of providing services and cause Federal hospitals to seek agreements with private sector.

If the reimbursement rate is mutually agreeable to both agencies at the local level, sharing will take place.

Finally, the House bill includes language which establishes VA hospitals as the primary backup system to the Defense Department in case of war. I support this concept and I feel it goes hand in hand with my bill to encourage sharing in peacetime.

We have a unique opportunity here to encourage interagency cooperation in the delivery of health care to millions of Federal agencies. This cooperation can set a valuable example for other agencies to follow.

I thank you, Mr. Chairman, for your thoughtfulness. Mr. Alan Mertz, a member of our staff at Government Affairs, a valued member who has worked on this legislation, would be very happy to work in close coordination with your committee. We will make certain that you do have the position of the Administration on this legislation and that it can be marked up as rapidly as possible to start getting into effect the tremendous cost savings and increase in service that is available as a result of this legislation.

Senator MURKOWSKI. Thank you, Senator. We very much appreciate your very valuable testimony, and the offer of your assistant, Alan Mertz. The committee certainly accepts his expertise and we particularly want to thank you for, I feel, an outstanding example that you presented before us of the situation as it exists in your State. It would certainly appear in the national interest that Federal medical facilities be properly utilized.

Recognizing your time constraints, the fact that you have a committee to chair, why of course you're excused, and again we want to thank you.

Senator PERCY. Thank you, Mr. Chairman, very much indeed.

Senator MURKOWSKI. While our committee is charged with assuring that our Nation's commitment to its war veterans is honorably fulfilled, we share with you the desire to improve the efficiency of all sectors of the Government. Enhanced efficiency in our operating programs is one way in which we can maintain the necessary levels of service to veterans while restraining the expenditure of tax dollars. Senator Percy's committee, through legislation such as S. 266, certainly has been instrumental in helping us toward achievement of the President's program for economic recovery.

At this time I would like to call on my colleague from the State of Maine, whom I certainly welcome, and would ask you if you have an opening statement to make, Senator.

Senator MITCHELL. Thank you, Mr. Chairman. I have a brief statement, which I will not read, but ask that it be inserted into the record in full. Let me just say that I commend Senator Percy for this initiative. This is a situation that exists in many States, including my own. Maine is a large and sparsely populated State. We have a situation where veterans from some parts of the State must drive 300 or more miles to get to the only Veterans' Administration facility, and on the way, they pass within a few hundred yards of a major Air Force base which has a large medical facility that could accommodate them were this legislation to be enacted and implemented.

And so I think it makes a great deal of sense, and I join Senator Percy in urging its approval and will be happy to participate with you, Mr. Chairman, and other members of the committee, in furthering this legislation.

And I have no further comments. At this time I ask that this be inserted into the record.

Senator MURKOWSKI. So ordered.

[The prepared statement of Senator George J. Mitchell follows:]

PREPARED STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Thank you, Mr. Chariman. I look forward to the testimony of Senator Percy and the other witnesses concerning the proposals for sharing medical facilities.

I would like to state at the outset that I favor the concept of sharing medical resources. Certainly no one can argue with the premise that whenever possible the Government should encourage efficiency and economy. It is possible to achieve significant savings by encouraging such cooperation among Federal agencies providing health care services. And it can be accomplished without obscuring or confusing the specific needs and goals of the separate agencies.

We should not allow veterans' programs to be tempered to achieve cost savings; nor should we encourage the weakening of military medical programs to achieve economy. We can, however, work for an expeditious and efficient arrangement between the DOD and the VA to achieve maximum benefit for those utilizing their services.

I have a particular interest in this subject because of the situation in northern Maine. There are over 13,000 veterans living in Aroostook County, Maine's northernmost county. The nearest VA medical facility in Augusta, Maine is over 300 miles from parts of Aroostook County. In many instances, it is simply not realistic for a sick or disabled veteran to attempt this trip to obtain necessary medical care. This is especially true during Maine's long and cold winters. Veterans who do make the journey to Togus for outpatient or hospital care travel within a few miles of the military medical facilities at Loring Air Force Base. The efficiencies that could be achieved by a sharing of resources in this situation are obvious. And I stress that I believe we can accommodate these arrangements with absolutely no harm to the basic missions of the respective health care systems.

I look forward to the comments of the witnesses on these proposals. Thank you, Mr. Chairman.

Senator MURKOWSKI. Thank you, Senator Mitchell.

I will enter into the record at this point a prepared statement of Senator Strom Thurmond.

[The prepared statement of Senator Strom Thurmond follows:]

PREPARED STATEMENT OF HON. STROM THURMOND, A U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

MR. CHAIRMAN: It is a pleasure to be here this morning to receive testimony concerning S. 266, a bill to establish a federal Interagency Medical Resources Committee; and, we will receive testimony regarding additional legislation that would enable the Veterans' Administration to fully cooperate with the Department of Defense in planning for the care of wartime casualties.

S. 266 was introduced in January 27, 1981 by our colleague from Illinois, Chuck Percy, and I would like to issue a warm welcome to him at this time. The goal of S. 266 is to promote and insure the most efficient and effective use of interagency sharing of medical resources between the VA and DOD. During this time of cost savings, I believe S. 266 advances a very meritorious goal and I look forward to the testimony regarding this legislation.

Mr. Chairman, we also will consider proposed legislation that would establish the VA as the primary reserve to the DOD medical care system during periods of war or national emergency. These two agencies would engage in contingency planning for resource sharing under emergency conditions and, during such periods, the Administrator could give a higher priority for hospital care to wounded active duty personnel than to non-service-connected veterans. Also, there would be authority for the VA to contract with non-Federal facilities for certain health-care needs during periods of national emergency.

Mr. Chairman, we have a distinguished list of witnesses today and I look forward to their testimony on these most important matters.

Senator MURKOWSKI. I assume all of us agree that reducing health-care costs while at the same time enhancing access to services for veterans are worthwhile goals. However, it is always appropriate to ask if new legislation is necessary. This committee is also particularly sensitive to the needs of veterans entitled to health care. The question is, would the legislation before us properly protect the needs of such veterans while seeking to attain national goals related to cost containment and preparedness?

This morning we would like to ask those of you testifying to share with us your views on these issues, as well as the advantages of the legislative solutions which have been proposed within the Senate and the House.

We would call the first witness, Mr. Gregory J. Ahart, U.S. General Accounting Office, Director, Human Resources Division, and he will be accompanied by Mr. David P. Baine, Group Director, Human Resources Division; and Darryl W. Dutton, Senior Evaluator of the Los Angeles Regional Office.

Mr. Ahart, I would welcome you to the committee this morning. We are going to limit the presentations to about 5 minutes or thereabouts, recognizing that we have a number of witnesses, and of course, any testimony that you care to submit for the record will be received by the Chair.

Would you be kind enough to identify, perhaps introduce your associates?

TESTIMONY OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY DAVID P. BAINE, GROUP DIRECTOR, HUMAN RESOURCES DIVISION; AND DARRYL W. DUTTON, SENIOR EVALUATOR, LOS ANGELES REGIONAL OFFICE

Mr. **Ahart**. Thank you, Mr. Chairman. On my right is Mr. Darryl Dutton, from the Los Angeles Regional Office, and on my left is Mr. David Baine, from the Human Resources Division.

I do have a statement which I will file for the record, and I'll try to be as brief as I can in summarizing our principal views on this legislation.

In short, we support congressional enactment of Senate bill 266 and agree with congressional authorization of VA to fully participate with DOD in planning for the treatment of returning battlefield casualties.

In our opinion, S. 266 constitutes a much-needed legislative statement of policy and guidance to the Federal Government's two largest direct health-care providers, DOD and VA, to more efficiently spend the billions of dollars appropriated annually to them for operating, constructing and equipping health-care facilities.

DOD's and VA's effective implementation of S. 266 should also, in our opinion, result in establishing a sound foundation for increased cooperation between the two agencies in planning and caring for returning wartime casualties, as envisioned by H.R. 3502.

Since 1975, we have invested considerable resources in dealing with the issue of sharing Federal health-care resources, and have issued numerous reports on this subject. A list of those reports, Mr. Chairman, is appended to my full statement.

Based on our work, we believe that increased sharing would benefit the Federal Government by providing opportunities for first, eliminating underused or duplicative facilities, equipment and staff; second, reducing the Government's growing reliance on health care delivery programs such as DOD's Champus and VA's Champva which provide care not available from the Federal direct health care providers; and finally, increasing staff efficiency and improving patient care by consolidating work loads and resources.

Also, in some cases, beneficiaries could be treated in Federal facilities closer to their residences, and save money, because they would not be required to pay portions of the cost of care.

In our June 1978 report, which Senator Percy mentioned, we identified the major obstacles to sharing as the absence of a specific legislative policy for interagency sharing and a lack of adequate headquarters guidance on how to share, restrictive agency regulations, policies, and procedures, and inconsistent and unequal reimbursement methods.

Our report also contained numerous examples where opportunities existed for sharing, which were precluded or inhibited by these obstacles. We believe that such opportunities and unfortunately such obstacles, still exist today and that legislation, such as S. 266, is very much needed to take advantage of sharing opportunities in a way which will be mutually beneficial to the Government and the beneficiary.

We have discussed in our full statement, several specific sections of Senate bill 266, and how they appropriately address specific obstacles to sharing we found during our work.

We also believe there is a need for legislation to enable VA to fully cooperate with DOD in planning for the care of returning wartime casualties. H.R. 3502, which was approved last month by the House Committee on Veterans' Affairs, would formally establish VA's health-care system as the primary backup to DOD's health care system for treating U.S. military personnel during war or national emergency.

The bill would establish a special priority for treating active duty military members during a war or national emergency, which would be second only to the priority of service-connected veterans for care in VA facilities.

The need for legislation which accomplishes these objectives was pointed out in our June 1980 report, entitled 'The Congress Should Mandate Formation of a Military, VA, Civilian Contingency Hospital System.'

DOD plans for VA to care for casualties not expected to return to duty. However, VA's longstanding mission has been to care for these veterans. Therefore, such a plan involves no real change in VA's responsibilities. We believe VA should be much more involved in planning and caring for all returning battlefield casualties, not just those not returning to duty.

We believe that the Congress should, as H.R. 3502 would, add the responsibility of caring for casualties expected to return to duty to VA's current mission, so that DOD and VA can take advantage of the time now available in peacetime to develop plans for using available Federal medical resources to care for battlefield casualties.

We have not commented on the detailed contingency-related provisions of H.R. 3502, since we believe that these should appropriately be addressed by DOD and VA.

However, we believe that a contingency hospital system which makes use of VA's medical resources for all categories of returning casualties, including those expected to return to active duty, would be an efficient and effective use of Federal medical capabilities.

We also believe that a strong peacetime medical resources sharing program such as that provided for in S. 266 should result in the establishment of a sound foundation for effective working relationships between VA and DOD, which could be invaluable in the event of war.

That summarizes our statement, Mr. Chairman, and we'd be pleased to answer any questions which you may have.

Senator **Murkowski**. Thank you.

[The prepared statement of Gregory J. Ahart and the GAO's responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the Committee, we are pleased to be here today to discuss two recently introduced legislative proposals to encourage the Department of Defense (DOD) and the Veterans Administration (VA) to cooperate more fully in providing health care to Federal beneficiaries both during peacetime and in the event of war. S. 266 would establish a Federal Interagency Medical Resources Committee to ensure, through increased sharing, the most efficient and effective use of Federal direct health care resources during peacetime. The other proposal, included in H.R. 3502, recognizes the need for VA and DOD to participate in joint contingency planning and raises the priority of members of the Armed Forces for treatment in VA hospitals during war or national emergency.

We support congressional passage of S. 266 and agree with authorizing VA to fully participate with DOD in planning for the treatment of returning battlefield casualties.

S. 266

In our opinion, S. 266 constitutes a much needed legislative statement of policy and guidance to the two largest direct health care systems--DOD and VA--to more efficiently spend the billions of dollars appropriated annually to them for operating, constructing, and equipping health care facilities. Legislation, such as S. 266, and DOD's and VA's effective implementation of it, should also, in our opinion, result in the establishment of a sound foundation for increased cooperation between the two agencies in planning and caring for returning wartime casualties as envisioned in H.R. 3502.

S. 266 addresses the obstacles to interagency sharing of medical resources identified, in our June 1978 report "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978). I would like to submit a copy of that report for the record.

Increased sharing would benefit the Federal Government by providing opportunities for:

--Eliminating underused or duplicative facilities, equipment, and staff.

--Reducing the Government's growing reliance on health delivery programs, such as DOD's CHAMPUS and VA's CHAMPVA, which provide care not available from the Federal direct health care providers.

--Increasing staff proficiency and improving patient care by consolidating workloads and resources.

Also, beneficiaries, in some cases, could be treated in Federal facilities closer to their residences and save money because they would not be required to pay portions of the cost of care. Legislation, such as that proposed in S. 266, is very much needed to take advantage of sharing opportunities in a way which will be mutually beneficial to the Government and its beneficiaries.

Background

As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries have continued to rise, and efforts have been made by the Federal agencies to explore ways of reducing costs without adversely affecting the quality of care provided to Federal beneficiaries.

This issue should be particularly important to DOD and VA officials because of their responsibilities for providing most direct health care to eligible Federal beneficiaries. Together, DOD and VA spent about $10.6 billion in fiscal year 1980 to provide medical care to their beneficiary populations. Hundreds of millions of these dollars were for care provided outside the Federal Government's direct health care systems.

Until recently, each Federal agency planned its health delivery system in terms of having sufficient services for the beneficiaries for which the agency had primary health care responsibilities without considering the needs and capabilities of other Federal agencies. However, in early 1978, a unified position on interagency sharing was taken by high-level representatives of the Government's major direct health care systems. The principal medical officials from DOD, VA, and the Department of Health and Human Services (HHS) agreed that one approach to providing the highest possible quality of care with the greatest efficiency was to accept common goals and to share resources.

The Federal Health Resources Sharing Committee was established in 1978. Its broad goal was to improve the overall quality of health care and reduce the excess consumption of scarce resources through coordinated planning arrangements.

The Sharing Committee committed itself to identify and promote opportunities for jointly planning and using the Government's health care resources. It provided a forum for agency medical representatives to cooperatively explore opportunities to share services and resources.

To accomplish its goals and objectives, the Sharing Committee used several legislative authorities which permit Federal interagency sharing. In our opinion, however, these authorities do not give agency officials the uniform and comprehensive legislative guidance needed to implement a full and effective interagency medical resources sharing program.

As part of its operating procedures, the Sharing Committee established subcommittees to (1) develop and propose guidelines and criteria for assessing and justifying the need for and appropriate location of specialized medical services, (2) develop and propose program utilization criteria, and (3) explore sharing opportunities in specific geographic areas. Subcommittees include those for cardiac catherization laboratories, computerized tomography scanners, cancer treatment facilities, and medical information systems.

In January 1980, the Chairman of the Sharing Committee approved the establishment of a legislation subcommittee. Its purpose was to give the Sharing Committee a review of the existing obstacles to resource sharing along with recommended actions for removing these barriers where possible. The subcommittee's work was used in developing S. 2958 (a bill similar to S. 266), which was passed by the Senate last year but not acted on by the House.

GAO Reports Support the Need for Increased Interagency Sharing of Medical Resources

We have invested considerable resources since 1975 in dealing with the issue of Federal health care resources sharing. The sharing of medical resources--particularly the more specialized and expensive ones--has the potential for significant budget savings to the Government and the taxpayer. Appendix I to our statement lists the GAO reports which address opportunities for interagency sharing of Federal medical resources. Many of these reports pertain to matters ultimately considered by the Sharing Committee in attempting to implement an effective sharing program. The Sharing Committee and its subcommittees have met regularly over the past 3-1/2 years and involved many medical and administrative support personnel from DOD, VA, and HHS. Nevertheless, these efforts have not, in our opinion, resulted in much substantive progress in implementing effective Federal interagency sharing arrangements. This is not to say, however, that no sharing is taking place between individual health care facilities in the Federal sector. Also, the Committee's efforts are continuing. For example, the Committee is considering establishing a permanent staff to focus on the process of identifying and promoting opportunities for joint planning and use of Federal medical resources.

Current sharing arrangements are being accomplished in the absence of a legislatively established environment which specifically encourages sharing. S. 266 would establish such an environment which should pave the way for substantially increased sharing of Federal medical resources.

Obstacles to Sharing

Our June 1978 report identified the basic reasons for the lack of substantive progress in taking advantage of the sharing opportunities as:

--The absence of a specific legislative policy for interagency sharing and a lack of adequate headquarters guidance on how to share.

--Restrictive agency regulations, policies, and procedures.

--Inconsistent and unequal reimbursement methods.

In most instances, one or more of these obstacles precluded attempts by, or inhibited the efforts of, local Federal officials to reach satisfactory interagency sharing arrangements.

We believe that attempts to share, whether initiated at the Federal hospital level or by an interagency group such as the Sharing Committee, are hindered by the same obstacles.

We concluded that the Federal Government has a unique opportunity to take the lead in medical resources sharing. Taking full advantage of this opportunity, however, requires action by the Congress and a concerted effort by the involved agencies to eliminate obstacles to sharing and establish a more efficient Federal health care delivery system. We strongly believe that the legislative and administrative obstacles to sharing could be eliminated without adversely affecting the level or quality of care given to the agencies' primary beneficiaries.

After carefully considering various alternative recommendations to overcome the obstacles we identified, we felt the paramount need was for legislation to require interagency sharing, when appropriate. Such legislation would encourage individual initiative without adversely affecting any Federal agency's current responsibilities or organizational and command structures. It would also give Federal hospital officials increased management options to make the best use of our Nation's medical resources.

We recommended, therefore, that the Congress enact legislation to specifically overcome the obstacles to sharing which we had identified.

GAO Supports S. 266

Legislation which establishes a Federal policy to promote Federal interagency sharing and removes restrictions on the types of services which can be shared would be both beneficial and timely in view of the increasing concern about the spiraling costs of health care. This legislation would also provide the impetus and direction DOD and VA need to make interagency sharing more a rule than an exception. S. 266 addresses the factors we believe are essential to implementing an effective medical resources sharing program.

For example:

--Section 2(a)(5) recognizes the importance of both VA's and DOD's current responsibilities and, therefore, reaffirms their respective missions. This is important to the agencies, and we believe their implementation of this legislation would enhance their ability to seek and obtain alternative sources of care for their beneficiaries while controlling rising health care costs.

--Section 2(b) states that the bill's purpose is to clarify and expand the authority of VA and DOD as direct health care providers to facilitate Federal interagency sharing of medical care and medical care support resources. This section is important because the resources to be shared would not be limited to direct medical services, but would include the ancillary support services (e.g., administrative, laboratory, and laundry) needed by Federal direct health care providers.

--Section 3(2) appropriately defines "beneficiary" as any individual entitled by law to direct health care furnished by either VA or DOD. However, the Acting Administrator of Veterans Affairs, in commenting on this bill, stated that neither VA's facilities nor its mission was designed to furnish health care services to military dependents. He suggested that "* * * it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency." (Underscoring supplied.)

Based on extensive work in this area, we believe that the exclusion of any specific category of beneficiaries from potential sharing arrangements would be too limiting and ill-advised. In this regard, we noted several instances where VA facilities were providing health care services to military dependents without detrimental effects on VA's primary beneficiaries. Services which VA facilities have the potential to provide to military dependents are wide-ranging and include nuclear medicine, radiation therapy, computed tomography scans, and laboratory services. These services do not necessarily require provision of inpatient hospital care.

We believe that S. 266 contains an appropriate definition of whom could be served under interagency sharing agreements, particularly in view of the direction in the bill (section 4(a)(7)(D)) that sharing will be accomplished on a referral basis which will not adversly affect the quality of care and priority of access for medical services of the providing agency's beneficiaries.

--Section 3(5) defines "negotiated cost" as the cost for services provided between Federal facilities as determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis in an equitable and consistent manner.

We believe a "negotiated" cost, rather than an "actual" or "full" cost as currently provided for in existing sharing legislation, is needed if an effective sharing program is to be implemented. These latter categories of costs do not necessarily represent the "out-of-pocket costs" of providing services since costs, such as salaries and utilities, would be incurred whether or not services were provided to other agencies' beneficiaries.

Any reimbursement mechanism adopted by the agencies should be flexible enough to encourage and permit negotiations between Federal hospital officials to determine acceptable rates of reimbursement for services shared. Negotiated reimbursements could be based, depending on individual circumstances, on all costs funded from current appropriations, incremental costs (costs in excess of fixed costs for an additional item of service), or even no cost. In any case, if the reimbursements are mutually agreeable to both parties, sharing will take place.

Also, as provided in section 4(a)(7)(F), the reimbursement must be credited to the specific facility which provided the medical service. Without such a provision, the incentive at the local Federal hospital level to share is diminished or lost, and including it in the bill should overcome one of the major obstacles to sharing we identified.

--Section 4(a) of the bill establishes a Federal Interagency Medical Resources Committee.

In our recommendation to the Congress for implementing an effective Federal medical resources sharing program, we recommended that responsibilities similar to those contained in section 4 be assigned to the Office of Management and Budget (OMB). However, OMB has consistently taken the position that the more formal oversight and coordination we recommended was not necessary. Instead, OMB, when considering interagency sharing issues, has preferred to rely on its budget examiners and other staff already working with the affected agencies.

S. 266 clearly delineates congressional policy on the issue of sharing medical resources and specifies that the Federal Interagency Medical Resources Committee's primary responsibility is to fully and effectively implement this congressional policy. The formal congressional recognition of the Committee as being responsible for implementing the provisions of S. 266 and reporting to the Congress on the progress of its implementation satisfies the intent of our report recommendation.

--Section 4(a)(6) requires the Committee to consult with other agencies which provide health care directly to Federal beneficiaries to encourage optimum delivery of such care. Although DOD and VA represent most of the Federal Government's direct health care resources and are responsible for providing health care to the largest segments of the Federal beneficiary population, other Federal agencies, including HHS, also provide care to specified categories of beneficiaries. Many of these persons have current or future eligibility for care in military and/or VA facilities (for example, commissiored Public Health Service and Coast Guard personnel). Although we originally recommended including HHS representation on the Committee, we believe this section along with section 4(b) should give DOD and VA the necessary latitude to coordinate their health care activities with these agencies when it is in their beneficiaries' and the Federal Government's interest to do so.

--Section 4(a)(7)(G) provides that sharing arrangements become operative when the facilities' directors or commanding officers agree to share, unless disapproved by the agencies' headquarters. We reported that VA Central Office procedures for reviewing and approving proposed formal sharing agreements submitted by local VA hospital officials were unnecessarily complex and time-consuming. The VA Acting Administrator, in commenting on this provision, stated that VA has made considerable progress in streamlining the sharing agreements' review process and did not believe this provision was needed.

We believe that formal approvals of individual sharing agreements by VA's Central Office before sharing is initiated at the local level is not necessary and could, as in the past, cause delay. VA's streamlined review process should permit timely review to assure that locally initiated sharing arrangements are in the best interests of VA and the Government without requiring Central Office approval before sharing begins.

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In summary, we believe the Federal Government has the opportunity to promote substantially increased sharing of its health care resources and achieve corresponding savings while maintaining, or even enhancing, the access to and quality of care provided to their beneficiaries. In our opinion, the enactment of S. 266 would represent a significant step in that direction.

NEED FOR LEGISLATION TO ENABLE VA TO FULLY COOPERATE WITH DOD IN PLANNING FOR THE CARE OF RETURNING WARTIME CASUALTIES

Legislative changes to VA's mission and responsibilities are needed for VA to fully participate in the planning for the care of returning battlefield casualties. H.R. 3502, which was approved in May 1981 by the House Committee on Veterans' Affairs, would formally establish VA's health care system as the primary backup to DOD's health care system for treating U.S. military personnel during war or national emergency. The bill would establish a special priority for treating active duty military members during war or national emergency which would be second only to the priority of service-connected veterans for care in VA facilities.

The need for legislation which accomplishes these objectives was pointed out in our June 1980 report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76). I would also like to submit a copy of this report for the record.

In this report, we expressed concern about DOD's development of a civilian-military contingency hospital system under which DOD augments its medical capability by making pre-arrangements with civilian sector hospitals for the treatment of returning casualties during a war or national emergency. Our principal concern focused on the fact that the extent to which VA could support DOD in treating such casualties had not been determined.

DOD's plan envisions VA caring only for casualties not expected to return to duty. However, VA's longstanding mission has been to care for such veterans, and such a plan involves no real change in VA's responsibilities. VA should be much more involved in planning and caring for all returning battlefield casualties, not just those not returning to duty.

We believe the Congress should, as H.R. 3502 does, add the responsibility of caring for casualties expected to return to duty to VA's current mission, so that DOD and VA can take advantage of the time now available in peacetime to develop plans using available Federal medical resources to care for battlefield casualties. The alternative--waiting until a national emergency occurs before fully involving VA--could, in our opinion, result in

- --unnecessary confusion during mobilization regarding where returning casualties should be sent for medical care,
- --underuse of VA's medical capabilities during war or conflict,
- --inability of DOD to know what the total Federal wartime medical capability is to identify the shortage which needs to be made up by the civilian sector, and
- --unnecessary effort and expense by DOD to identify and contract for civilian medical resources.

In our opinion, the Nation should prepare for a possible conflict by planning to fully use Federal medical resources before calling on non-Federal resources. We believe that a contingency hospital system which uses VA's medical resources for all categories of returning casualties, including those expected to return to active duty, would be an efficient and effective use of Federal medical capabilities. Moreover, we believe that a strong peacetime medical resources sharing program, such as that provided for in S. 266, should result in the establishment of a sound foundation for effective working relationships between VA and DOD, which could be invaluable in the event of war.

This concludes my statement, Mr. Chairman. We will be happy to answer any questions you might have.

GAO REPORTS DEALING WITH OPPORTUNITIES FOR SHARING OF FEDERAL MEDICAL RESOURCES

"Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital" (MWD-76-117, Apr. 7, 1976)

"Congressional Policy Guidance Should Improve Military Hospital Planning" (HRD-77-5, Nov. 18, 1976)

"Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control Needed" (HRD-76-168, Feb. 28, 1977)

Letter Report on "VA's Process to Determine Size of New and Replacement Health Care Facilities" (HRD-77-104, May 20, 1977)

Letter Report on "Operation of PHS Hospitals and Clinics as Required by Public Law 93-155" (HRD-77-111, May 26, 1977)

"Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977)

"Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions" (HRD-78-41, Jan. 30, 1978)

"Constructing New VA Hospital in Camden, New Jersey, Unjustified" (HRD-78-51, Feb 6, 1978)

"Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals" (HRD-78-102, May 17, 1978)

"Better Coordination Could Improve Provision of Federal Health Care in Hawaii" (HRD-78-99, May 22, 1978)

"Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978)

"Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42, Feb. 7, 1979)

"Military Medicine Is in Trouble: Complete Reassessment Needed" (HRD-79-107, Aug. 16, 1979)

"Health Costs Can Be Reduced by Millions of Dollars If Federal Agencies Fully Carry Out GAO Recommendations" (HRD-80-6, Nov. 13, 1979)

"Inpatient Care at Quantico Naval Hospital Should Not Be Resumed" (HRD-80-26, Nov. 29, 1979)

"The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (HRD-80-76, June 26, 1980)

"Sharing of Federal Medical Resources in North Chicago/Great Lakes, Illinois, Area" (HRD-81-13, Oct. 6, 1980)

RESPONSE OF THE GENERAL ACCOUNTING OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. You endorse the new Federal Interagency Medical Resources Committee proposed in S. 266. How would it relate to the existing Federal Health Resources Sharing Committee, or would it replace it?

Answer 1. The existing Federal Health Resources Sharing Committee (FHRSC), consisting of the principal medical officials from the Department of Defense, Veterans Administration and Department of Health and Human Services, provides a forum for these agencies to cooperatively explore opportunities for sharing medical resources. However, because S. 266 would provide formal congressional recognition of the new Federal Interagency Medical Resources Committee as the leader of an interagency effort to share medical resources, we believe it would assume the responsibilities of the existing committee, as well as others, to carry out the provisions of the legislation.

While the new committee would consist only of representatives from VA and DOD, S. 266 provides that the committee shall consult, when appropriate, with other Federal health providers. Such an arrangement would permit the continuation of the coordination efforts currently underway by the FHRSC and the continued participation of other Federal providers.

Question 2. In your testimony, you advocate reimbursement on the basis of costs "negotiated" by hospital officials. Although such local authority could be helpful in stimulating sharing, shouldn't there also be a central cost review mechanism to assure that the best interest of the respective agencies are being met from a national perspective?

Answer 2. As we stated in our June 1978 report[1/] we believe that the reimbursement mechanism should be flexible enough to permit nego-

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[1/] "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978) tiations between local hospital officials to determine acceptable rates of reimbursement for services shared. These could range from no reimbursement (even exchange) to reimbursement of full costs of providing services. We believe that agencies' centralized efforts to standardize sharing reimbursement rates to cover all circumstances will--as has been the case in the past--hamstring the local hospital directors in their efforts to share their capabilities.

S.266 provides that such sharing arrangements become operative when the facilities' directors or commanding officers agree to share, unless disapproved by the agencies' headquarters. We believe that this review process should permit timely review to assure that locally initiated sharing arrangements--including the reimbursements involved--are in the best interest of the Government.

Question 3. Would the contingency planning process, which is national and regional in scope, be related to the disparate peacetime sharing efforts at individual hospitals around the country?

Answer 3. We believe that the contingency planning process would be effectively bolstered by having a strong peacetime sharing program underway. Instead of having numerous VA and military medical facilities located near each other but unaware of each other's resources and capabilities, they would work closely together sharing resources on a day to day basis. The knowledge of each others' capabilities and procedure could be invaluable in the event of war. Working relationships could already be established, lines of communications opened, and procedures developed which would greatly enhance the speed and efficiency with which casualties could be treated and moved between and among DOD and VA health care facilities.

Question 4. The House and Senate have taken different approaches to legislation supporting sharing. Aside from substantive differences in their provisions, would it be preferable to adopt free-standing legislation as in S. 266, or amend title 38 as in H.R. 3502?

Answer 4. We believe that free-standing legislation such as S. 266, would be preferable to legislation which amends specific sections of the agencies' existing authorities. The legislation we recommended would, as S. 266 does, establish that it is the Congress' intent to encourage interagency sharing, wherever practical, without disrupting the agencies' provision of services to their primary beneficiaries. We believe that legislation which amends one or perhaps both agencies' statutes has the potential to become too limiting insofar as what could be shared and under what circumstances. It should be recognized that both agencies already are permitted to share under their existing authorities but have not done so extensively because of other constraints of law and regulation which still could exist following an amendment process.

RESPONSE OF THE GENERAL ACCOUNTING OFFICE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. On page 5 of the American Legion's testimony, the concern is raised that OMB would take advantage of any opportunity involving cost sharing to automatically offset fund allocations to the agencies, or elements thereof, to the extent that reimbursements are made.

This seems to me to be a valid point. In an era of great emphasis on cost-savings like we are in at present, what would prevent OMB, in the event that, for example, DOD paid $500 million to the VA in a particular year as reimbursement for services provided to DOD personnel by VA, from automatically reducing the VA's funding by that full amount? If such a complete offset were to be made automatically, wouldn't that seriously affect any incentive for sharing?

Answer 1. We agree that any such action on the part of OMB would seriously affect any incentive for sharing and that such action would be a serious blow to interagency sharing. We pointed out in our 1978 report that the lack of effective and uniform reimbursement mechanisms is the major obstacle to increased sharing and that any corrective action must incorporate an incentive to share. Currently, VA allocates reimbursements for services provided under sharing agreements made pursuant to 38 U.S.C. 5053 back to the providing VA hospitals. Such allocations have provided a major incentive for VA hospitals to share specialized medical resources with non-Federal institutions. A similar incentive should be permitted to encourage sharing among all Federal health care providers.

Question 2. On page 7 of the American Legion's testimony, the suggestion is made that peacetime sharing legislation should include a sunset provision. Do you believe that such a provision should be a desirable feature and, if so, how long an active period, prior to the sunset point, would you recommend?

We do not believe that the proposed medical resource sharing legislation should include a sunset provision. We pointed out in our 1978 report that legislative and administrative obstacles prevent the effective use of health care delivery resources and that legislation is needed to establish a greatly expanded and cost-effective interagency sharing program. Further, we believe that the provision in S. 266 which requires the Federal Interagency Medical Resources Committee to report annually to the Congress on its activities and progress should provide the Congress with sufficient information concerning the extent to which sharing is taking place and the need, if any, to modify the legislation.

Question 3. Aside from ensuring that reimbursement is credited to a specific facility which provides a medical service, as advocated on page 10 of your testimony, what other actions could be taken to provide incentives for sharing?

Answer 3. Our June 1978 report pointed out a number of obstacles to effective interagency resource sharing and the actions needed to encourage more sharing, including reimbursing the providing hospital with any revenues received. Other actions needed include:

--a congressional policy encouraging interagency sharing to the maximum extent practicable consistent with the respective agencies' missions;

--authorization for Federal facilities to care for all categories of Federal direct care beneficiaries on a referral basis;

--elimination of restrictions on the types of services to be shared;

--approval of sharing agreements at the local level, subject to headquarters' reviews;

--establishment of reimbursement mechanisms based on negotiated costs.

S. 266 provides all of the above incentives and should go a long way toward encouraging medical resource sharing among Federal health care providers.

Question 4. In your discussion of the reimbursement issue, you advocate a great deal of local flexibility. I am concerned that total local flexibility might lead to facilities swapping various resources without reference to the actual cost of the services being swapped. Do you think this might occur?

Answer 4. We believe that any reimbursement mechanism should be flexible enough to encourage and permit negotiations between local Federal hospital officials to determine acceptable rates of reimbursement for services shared. Such reimbursements could be based on all costs, incremental costs, an exchange of services, or even no costs. If reimbursements are mutually agreeable to both parties, sharing will take place. We believe that the provision in S. 266 which permits agency headquarters' review and, if appropriate, disapproval of such agreements should assure that locally-initiated sharing arrangements are in the best interest of the Government.

Question 5. S. 266 would seem to establish "maximum" VA/DOD sharing of medical resources as national policy, and to require various steps to carry out such a policy. For example, section 4(a)(4) of S. 266 would require a VA/DOD interagency medical resource committee to "prescribe policies and procedures designed to maximize interagency sharing of (VA and DOD). . . medical resources.." Although I strongly favor eliminating unnecessary and inadvisable duplication of VA and DOD health-care resources, I have serious doubts that a policy requiring maximum sharing would always be wise. Thus, if in a particular metropolitan area the VA and DOD each saw the need for its own

500-bed general, acute-care hospital, it could be argued that a policy of maximum sharing would mean that one of the agencies should build a 1,000 bed facility and the other should purchase health-care services from the one operating the facility. For a great variety of reasons, I don't believe that that would necessarily be a desirable result; and, although this may be an extreme example, I believe that it illustrates the problems involved in overemphasizing sharing. What is your response to this kind of concern regarding the very strong approach taken in S. 266?

Answer 5. We believe that S. 266 provides a legislative statement of policy and guidance needed by Federal direct health care providers to more efficiently use their resources. Presently, no such guidance exists and agencies must often obtain medical services for their beneficiaries through very expensive purchases from the private sector or by transporting patients a long distance. We feel that the policies and procedures prescribed in S. 266 would strongly promote interagency sharing as a normal way of doing business, consistent with the agencies' respective missions.

It is anticipated that the Federal Interagency Medical Resources Committee established under S. 266 would be cognizant of the respective agencies' plans for facilities and equipment and would assure that the plans were consistent with (1) the health care needs of the Federal beneficiary population in the area and (2) the efficient provision of care to meet those needs. Under S. 266, sharing should proceed only when it supports each agency's mission and should be maximized to the extent practicable within these limits.

Senator **Murkowski**. Is there going to be a presentation by your associates?

Mr. **Ahart**. No. My statement will stand, Mr. Chairman.

Senator **Murkowski**. Thank you, Mr. Ahart.

You indicated that there was a question of establishment of legislative policy on how to share. I assume that within the scope of your agency's responsibility, you go to various agencies with the idea of improving efficiency and various other things.

In this particular concept of sharing, did you issue a report to either the DOD or the VA on your recommendation for sharing?

Mr. **Ahart**. Yes, we have, Mr. Chairman.

Senator **Murkowski**. Did that report refer to how to share?

Mr. **Ahart**. The report documents quite a number of efforts by the local commanders of military hospitals and the local directors of VA hospitals where they have been unable to work out sharing arrangements.

I think most of them, left to their own devices, could figure out how to share where it makes sense to do it. The problem is that there are legislative barriers, there are administrative barriers, there are requirements within the different agencies as to what procedures they must go through to get approval of these sharing agreements.

There are problems in terms of the basis upon which they ought to reimburse one another for the services which are shared. In the final analysis these problems inhibit their willingness and their capacity to work out sensible arrangements at the local level.

In our report which was issued to the Congress in June of 1978 and which provided, I think, a lot of the input into the development of the bill passed last year by the Senate, we point this out. We feel that there's a very strong need for a legislative direction for sharing and that many of these administrative problems should not get in the way of the local commanders and directors, in working out arrangements that make sense, are economical, and better meet the needs of the beneficiaries of the agencies involved.

That's really the thrust of the message of this report. It's the thrust of S. 266. It was the thrust of the bill which was passed by the Senate last year. And we think that the legislative direction is needed. We feel that the agencies have been a little bit reluctant and I think to some extent understandably so, because there has not been the clear policy that sharing should be carried on where it can be.

There has been permissive sharing over the years, but because of these obstacles, it has not developed to the point where it is nearly as significant as it could be under the provisions of S. 266.

Senator **Murkowski**. Let me ask you this. In your contacts with representatives of the DOD and the VA hospitals in regard to the sharing concept, have you met with enthusiastic response to the idea of sharing or has there been a negative response?

Mr. **Ahart**. I would say that I think there is some distinction that has to be drawn as you go through the different echelons of the agencies, depending on which agency it is.

We visited some 90 facilities and talked to people in those facilities during the course of our various studies. In general we found that there was a lot of enthusiasm for sharing. Where physicians knew that somebody next door or hospitals nearby had diagnostic or treatment equipment which they did not have in their own facility and where they wanted to meet the needs of their patients, they would have liked to have been able to access that equipment. At the same time many of them would like to have the opportunity to treat a wider range of patients by more fully utilizing the capabilities in their own facilities.

In general, there was a high degree of enthusiasm. I think that as you go to the higher echelons in the agencies, there is a natural incentive for them to pay more attention to some of the administrative requirements. I hate to use the term, but the "bureaucratic elements" get involved in working out arrangements between two major agencies.

Senator MURKOWSKI. Is there a fear expressed or implied that by working closer together the efficiency might develop to the point that beds could be eliminated and in consequence some budgets might be reduced. For that reason, would there be a reluctance to support the idea of sharing?

Mr. AHART. I don't know if we could speak terribly well to the motivations behind the difficulties associated with the finalization of sharing agreements between the two agencies.

Senator MURKOWSKI. Well, do you feel that situation might occur? It's something that would have to be addressed if we did seriously set up a workable sharing system. Or, are those administrators mature enough to resolve their own turf differences, so to speak?

Mr. AHART. I think it really comes down to this, Mr. Chairman. In the absence of a clear legislative mandate to share where it makes sense, and only provisions on the books which allow sharing on a permissive basis, agency administrators really don't have an outside setting of priorities on what they ought to be worried about. As it is now, with the permissive sharing, I think there's an inclination to worry about sharing, but also an inclination to worry an awful lot about the administrative niceties which get involved, if you have to work out something between the Secretary of Defense and the VA Administrator.

What this bill would do would be to unencumber the process but still leave each agency in a position to veto the local sharing arrangements when they felt that what was worked out was not in the Nation's best interest.

Senator MURKOWSKI. Mr. Ahart, you indicated that you felt some of the stumbling blocks were in the administrative area, the legislative area, and the manner in which reimbursement would be established. Basically these are mechanical problems that would have to be overcome.

In your opinion, it's the duty of each particular Government agency to pick up where your agency left off to coordinate the refinement of these mechanics so that a procedure can be established so that we can move on? Obviously, you can say it's the Congress. But by the same token, they're not efficiency experts. You've identified the problem; who coordinates and puts the problem in a package and delivers it to Congress for action?

Mr. **Ahart**. We do think this legislation is very worthwhile, and would move the whole sharing concept in the direction it ought to go.

In answer to your specific question, the natural agent to get this done in the executive branch is the Office of Management and Budget.

Senator **Murkowski**. Do you have comments on what they've done so far?

Mr. **Ahart**. Well, we have found that they have taken, in our judgment, a rather standoffish position. When we submitted our draft report to them in 1978, we had a recommendation that they set up within OMB, a group which would pay particular attention to this and try to facilitate the working out of these arrangements on an administrative basis.

Senator **Murkowski**. In other words, you are saying that they had a standoff position, and I am told today that we do not have the firm recommendation that we had hoped to have this morning. So I assume that the posture of the committe with regard to the position of OMB is the same. We are still not satisfied with the direction that we're being given.

Would you concur with that?

Mr. **Ahart**. Well, I can't really comment on what might have happened in the last few days or months in trying to put together the current administration's position on this. I was speaking to what happened in 1978. Their preference was to go with the Interagency Committee. We thought the Interagency Committee was helpful. We felt that a more active role by OMB would certainly have been helpful to the process.

OMB preferred to rely on its traditional budget review function as the basic tool to try to encourage this.

We think that S. 266, which would legislatively endorse the Interagency Committee and give it a specific role and a legislative mandate, is probably a good substitute for what we had expected would be a natural role for the OMB.

Senator **Murkowski**. I have a few prepared questions which I will submit to you, and if you could respond briefly.

Concern has been voiced about the imminent situation facing beneficiaries in the care of the U.S. Public Health Service. Do you believe it would be possible to integrate public health service care into the proposed Veterans' Administration and Department of Defense resource sharing plan? I think you've already answered that in the affirmative. Is there anything you'd care to add?

Mr. **Ahart**. Our original concept was that the bill should probably encompass the Public Health Service, as well as DOD and VA. There are reasons why the bill has been changed to place the primary focus on DOD and VA. We feel that the impetus in the bill which would put a focus on the Interagency Committee working out arrangements——

Senator **Murkowski**. You said, Public Health Service should be included?

Mr. **Ahart**. That was our original thought and our original recommendation. We think that so long as there's good will in the Interagency Committee working on this problem and a mandate is in the legislation to try to work out sharing wherever it makes sense, that's probably pretty well taken care of.

Senator Murkowski. Why have you dropped Public Health Service from your——

Mr. Ahart. We didn't drop it. That was a legislative consideration when the bill went through the Senate last year, and I think a part of that was the result of some Veterans' Administration problems with the inclusion of the Public Health Service.

I couldn't speak in too much more depth to the specific reasons why it was dropped.

Senator Murkowski. It's my understanding that there are some eight Public Health Service hospitals throughout the United States that are going to be closing down; merchant seaman on documented vessels are not going to be able to avail themselves of these facilities, as a consequence of the budget reduction.

These facilities, nevertheless, are in existence. I'm wondering, has any consideration been given to the sharing of these facilities as well?

Mr. Ahart. I think we're getting into some issues we haven't considered. Specifically, Mr. Chairman, we have recently issued a report dealing with the PHS hospitals which deals with the ways money could be saved if that system were not discontinued. However, we would have no particular argument against discontinuing it.

Senator Murkowski. Well, if they were discontinued, we're talking about a lot of people: seamen, fishermen, and others. I assume that, in the full spirit of cooperation that would mean that the DOD facilities and the VA facilities would be made available, in addition to the Public Health Service.

Mr. Ahart. I think under S. 266, as it's drafted, there would have to be a determination made that they are in fact, Federal beneficiaries. There would also have to be a determination that any care given to them would not be detrimental to carrying out the main mission of the Veterans' Administration in its case or the DOD in its case.

Senator Murkowski. They're covered under a different public law.

Mr. Ahart. They are covered under a different public law and constitute different beneficiary categories.

Senator Murkowski. What would be the cost of integrating the Public Health Service hospitals into the sharing plan, do you know?

Do you have an idea?

Mr. Ahart. The cost of integrating them into the sharing plan? I don't think we could answer that, Mr. Chairman. I think it depends on how that was worked out. There are a lot of people that are being served by the Public Health Service today which we're not too sure ought to be receiving service. We have some question as to whether many of the people that are in Public Health Service facilities ought to be in there.

If it is determined that the Government has the responsibility for providing these people care, providing such care throught sharing arrangements should not result in a net cost but rather it should result in a net savings. Also such sharing arrangements should be worked out without detriment to the primary mission of either the DOD or the Veterans' Administration.

I might ask Mr. Baine if he has any further thoughts on that. He may have given it more thought than I have.

Senator MURKOWSKI. Mr. Baine?

Mr. BAINE. As Mr. Ahart said, I don't believe we have an estimate of the cost of doing what you suggested. It should be recognized too that the Public Health Service hospitals' inpatient and outpatient beneficiaries in many cases have dual eligibility. They are also eligible for care in Defense hospitals, and in some instances, VA hospitals.

So some portion of the Public Health Service's patient load, you could naturally go to the Defense Department hospitals or the VA hospitals because of the beneficiaries' dual eligibility.

Senator MURKOWSKI. What would be the cost of only integrating merchant seamen along with active duty and retired members of the Coast Guard and their dependents?

Mr. AHART. Again, I don't think we have an estimate on that. The Coast Guard would fall into the dual beneficiary category which Mr. Baine just mentioned, so they are now free to go to either PHS or DOD facilities and can be served at either.

Merchant seamen would be a new category of beneficiaries for DOD and VA. We have not studied what the cost would be and could not give you an estimate on that.

Senator MURKOWSKI. Wouldn't it be appropriate to get some cost figures at this time, to make sure that we don't go through this again and wish we had included the Public Health Service hospitals?

I mean, it seems like we're in a period of examination of our facilities with the idea of an attempt to increase our efficiency, with greater utilization. I just wonder if it would be appropriate for your agency, since there are eight Public Health Service hospitals, to do some research to determine whether these should be picked up by the DOD and VA or whether we should forget it.

Mr. AHART. I think certainly that would be useful information. The specific things that would have to be considered would depend on, given whatever legislation is passed, the continued entitlement of current Public Health Service beneficiaries and just where those beneficiaries that would continue to be entitled to care would go for such care.

I think, rather than our agency doing it, it might be much more expeditious if the Department of Defense, the Department of Health and Human Services, and the Veterans' Administration would collaborate on the implications, given different scenarios as to what might be included in the legislation and what treatment might be afforded the different classes of beneficiaries which the Public Health Service hospitals now treat.

We would basically have to go to those agencies to get the information and pull it together anyway, and I think that they would probably be in a position to do it much more expeditiously than we would.

Senator MURKOWSKI. I think it would be appropriate, and I will communicate with Chairman Simpson to request that a letter be written asking you to look into the inclusion of the Public Health

Service hospitals. As I understand, the Act for the Relief of Sick and Disabled Seamen of 1978 is going to be terminated. As a consequence, those facilities and services will no longer be available to merchant seamen and fishermen.

I would like to welcome my colleague to the hearing this morning, Senator Cranston.

We have had an excellent presentation from Senator Percy on the need for utilizing and combining for greater efficiency the facilities of the VA and the DOD. I would invite your participation and your statements or questions.

We have before us Mr. Gregory J. Ahart and his associates David Baine and Darryl Dutton.

Senator CRANSTON. Thank you very much.

I do have an opening statement that I would like to enter into the record.

I also have a few questions I would like to pose in writing.

I would like to call attention to the fact that there is a CAT scanner—a mobile CAT scanner—on display at the east front of the Capitol. It demonstrates a means for the sharing of technology—the mobile use of technology.

I would like to ask that a statement about that display appear in the record.

Senator MURKOWSKI. Without objection.

[The written statement in reference to the CAT scanner follows:]

MOBILE CAT SCANNER
TO VISIT CAPITOL HILL, JUNE 16/17

A mobile CAT scanner will be on display at the East Front of the Capitol on June 16th and 17th.

A significant breakthrough in medical technology, the mobile CAT scanner is one of a fleet of 26 owned and operated by American Medical International (AMI), a California health services firm.

Lawmakers and government health officials have shown great interest in this remarkable piece of medical technology which makes a highly regarded and sought after diagnostic tool available to hospitals which, on their own, could not economically justify the acquisition of a CAT scanner.

The CAT scanning technique takes thousands of simultaneous x-rays and, via computer, displays them on a video screen. CAT scans are far more detailed than regular x-rays and in many applications eliminate the need for exploratory surgery. AMI's mobile scanner, made by General Electric, embodies an advanced design that vastly reduces the time and exposure needed to conduct a scanning.

The Capitol Hill visit of the mobile scanner is sponsored by Senator Alan Cranston and Congressman Henry Waxman, both of California. Cranston is the Democratic Whip in the Senate. Waxman is Chairman of the Health Subcommittee of the House Commerce and Energy Committee. The CAT scanner will be parked on the Senate side of the East Front and visiting hours will be from 9:00 a.m. to 5:00 p.m. Technicians will be on duty to demonstrate and explain the scanner's operations to interested legislators, staffers and government officials.

The development of the mobile scanner is a technological breakthrough that enables patients in small- and medium-sized community hospitals to receive the same quality of diagnostic care for neurologic disorders and other diseases now available only in large, urban institutions.

By the simple process of pulling the scanner up to the side of the hospital and plugging into a specially-installed electrical outlet, patients are able to move into the vehicle and onto the scanning table by means of a special lift. On-board film viewing capability is available for hospital diagnosticians. All components are specially "hardened" to withstand the demanding requirements of a mobile environment. In addition, the equipment is re-calibrated after each use. Thus, in addition to cost savings, in-patients are able to avoid traumatic and sometimes risky travel to fixed CAT scanner locations.

Each mobile scanner can serve about 800 beds - or 4 to 5 community hospitals. The savings achieved by this shared service not only result in reduced cost but also upgrade the quality of care provided by community hospitals. The dimensions of the savings are apparent from the fact that each mobile CAT scanner costs about $800,000, compared with an in-hospital installation, which, with the necessary room modifications, usually runs to about $1,000,000. In addition, maintenance on an in-hospital scanner costs $150,000 to $165,000 a year, plus another $100,000 for technicians. In a mobile scanner all these costs are shared.

The development of such shared services follows policies established by the Congress in the National Health Planning and Resources Act which states that "the development of multi-institutional systems for coordination or consolidation of institutional services deserves priority consideration."

CAT scanner technology has progressed very rapidly since its developers, Godfrey Hounsfield and Allan Cormack, received the Nobel Prize for Medicine in 1979. Thus, an additional advantage of mobile scanners is that they save hospitals the necessity of continually expending funds for equipment upgrades.

AMI presently has 30 additional mobile CAT scanners on order at a cost of $27 million. These units will be able to serve 200 additional hospitals. Within five years AMI hopes to be serving 5,000 hospitals with scanner-equipped vans. Plans are now being made to introduce the service to New England and at least seven southeastern states, in addition to present service in California, Texas and Florida.

American Medical International owns, operates, and develops hospitals throughout the world and provides a variety of health care services to more than 500 communities on six continents.

Senator MURKOWSKI. Thank you, Senator. Your questions will be directed to the various witnesses as identified, and we very much appreciate your attendance, and continued dedication to the Veterans' Affairs Committee.

Thank you, sir.

Senator CRANSTON. Thank you very much.

I am sorry I am unable to stay for Dr. Moxley, in particular, because I would like to hear your briefing on contingency plans.

[The prepared statement of Senator Alan Cranston follows:]

PREPARED STATEMENT OF HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Good morning. I am pleased to be here this morning. I look forward to hearing the views of the Committee's witnesses on the two inter-related issues before the Committee today involving the health-care resources of the Veterans' Administration and the Department of Defense. Those issues are:

First, the potential for greater sharing of VA and DOD resources during peacetime so as to yield increased efficiency in the Federal health-care sector, while continuing to recognize and respect the separate missions of the two agencies; and

Second, the appropriate role for the VA's health-care system as a back-up to the medical resources of the Department of Defense in the event of armed conflict when U.S. military casualties might overwhelm DOD's ability to provide the needed care.

One of the measures before the Committee today is an Amendment—No. 62—that I submitted for printing last week. The text of this amendment is identical to a measure, H.R. 3502, reported by the House Committee on Veterans' Affairs on May 19. As I noted at the time I introduced this amendment, I did so to be certain that, in our deliberations on these issues, we would consider codifying in title 38 any changes that we believe are necessary to facilitate greater sharing. This is the appropriate part of the United States Code, I believe, to locate the type of changes contemplated by the various measures before the committee.

I have long believed and stated that the VA has a very important role as the primary back-up to the relatively meager health-care resources of DOD in the event of armed conflict. On the issue of peacetime sharing, I certainly favor the sharing of resources between VA and DOD as long as the primary missions of the two agencies are fully recognized and protected. What I am not yet clear about, however, is whether there is a need for more legislation in these areas or whether, alternatively, what is needed is that greater flexibility be exhibited, within existing law, by the VA and DOD in their dealings with one another.

Finally, to the extent, if any, that legislative solutions are needed, I feel strongly that the specifics of these solutions must be very carefully drawn, and given the continued inability of the Administration to reach a position on the pending legislation, I agree with the decision that we not proceed to markup as scheduled for next week.

I look forward to receiving the views and guidance on the pending legislation from the witnesses this morning.

Senator MURKOWSKI. Just a couple more questions.

Do you anticipate that the efficiencies resulting from resource sharing would result in a reduction in the number of beds?

If so, how do you expect that would be handled? Would they go into storage?

Mr. AHART. I think that it is hard to say whether or not there would be an actual reduction in the number of beds in any kind of a short-term sense, Mr. Chairman. I would expect that with experience with sharing, these are the kinds of considerations that would be including in the planning for new facilities and so on.

It may be that there would be some reduction in the number of beds put in new or planned facilities. A lot of the sharing that we are talking about is the sharing of things which are done on an outpatient basis and don't require inpatient beds, as such.

So to the extent that it is the outpatient type services, the diagnostic services, and so on, which are shared, there is really no effect at all on the number of required inpatient beds.

Senator **Murkowski**. I think that you have been most responsive to our questions and I compliment you on your presentation this morning. I think you can anticipate a request in letter form from the committee asking you to address the area that we discussed in regard to the Public Health Service.

What facilities should be retained, and what obligation does the Federal Government have to maintain service for seamen and fishermen? Is this relevant to the sharing concept? I think it will be appropriate to ask whether the official attitude of the administrators representing the DOD and the VA would welcome that additional influx in responsibility as well.

Obviously, as you may have observed, being from the State of Alaska, I have a parochial interest in the continuation of those facilities inasmuch as our area is very dependent upon the fishing industry and the merchant marine.

It is fair to warn you that there may be further questions in writing.

In any event, thank you, gentlemen. We do appreciate your testimony.

Mr. **Ahart**. Thank you, Mr. Chairman.

Should we receive that letter from the chairman, we will try to be as responsive as we can to the needs of the committee.

Senator **Murkowski**. Thank you.

We are changing the agenda a little bit, which is the prerogative of the Chair, and ask Dr. John H. Moxley, Assistant Secretary of Defense, Health Affairs, accompanied by Lieutenant Colonel Reed and Lieutenant Colonel Burke, to present their testimony next.

Gentlemen, I would welcome you to the committee this morning and I am sorry that more of my colleagues aren't able to be here for your testimony, but I am sure that they will read with interest your remarks in the record.

Dr. Moxley, I would ask that you identify and perhaps introduce your associates.

STATEMENT OF JOHN H. MOXLEY III, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), DEPARTMENT OF DEFENSE, ACCOMPANIED BY LT. COL. PODGE REED AND LT. COL. DAVID BURKE

Dr. **Moxley**. Thank you, Mr. Chairman.

On my right is Lt. Col. Podge Reed, who is part of our Medical Readiness Office.

On my left is Lt. Col. David Burke, who is the staff director of the Defense Health Council and a member of my direct office.

I have a very brief statement which I would like to read.

I am pleased to respond to the committee's request for testimony concerning S. 266, the Federal Interagency Medical Resources Sharing and Coordination Act of 1981. I have testified previously in favor of similar proposals which seek to improve interagency medical resource sharing, including last year when we did testify before Senator Percy's committee, and I testified with the three surgeons general of the military medical departments, all of whom express their support, also, for the bill.

The concept of sharing medical resources has been embraced by DOD for some time and has served as the basis for developing the Department's own system of regionalization to facilitate areawide sharing of Army, Navy, and Air Force medical facilities by all DOD beneficiaries.

More recently, however, our requirement to share medical resources has extended beyond the Department of Defense to other Federal agencies. In recognition of this need, a Federal Health Resources Sharing Committee, called FHRSC, was established in 1977 with representation from the Department of Defense, the Veterans' Administration, and the Public Health Service.

The FHRSC has established utilization criteria for certain high-cost, high-technology specialty services as a preliminary step in identifying Federal health facilities having the potential to share these services.

The proposed legislation under consideration today is an attempt to meet a well-recognized need to facilitate sharing arrangements between Federal agencies by removing certain obstacles to sharing which have often interfered with efforts by Federal hospital officials to initiate local sharing arrangements.

S. 266 would provide incentives to encourage greater interagency sharing, thereby improving access for Federal beneficiaries to health care while reducing costs, yet providing sufficient safeguards to protect the primary beneficiaries of the agencies concerned from being adversely affected. The bill would also provide authority for the Federal Health Sharing Committee to conduct its oversight role in a more effective manner.

Accordingly, the Department of Defense favors the enactment of S. 266.

With regard to the proposal to incorporate provisions of H.R. 3502, establishing the VA as the primary backup to the Defense Department for medical contingencies associated with war or national emergencies, the administration will be reviewing this issue in context with other broad national security implications during the next few months. Consequently, the Department of Defense is not able to take a formal position on the proposal at this time.

There is no doubt, however, that a problem will exist in providing care in this country for all of the casualties we would expect to result from a NATO-Warsaw Pact war. The total combined capabilities of both the Department of Defense and the Veterans' Administration would still be insufficient to meet the demands for hospital care.

It is for that reason that we are vigorously pursuing the implementation of voluntary agreements with civilian hospitals across the country to provide backup should it be needed.

This effort is called the Civilian-Military Contingency Hospital Service.

We are placing heavy reliance on our planning for hospital care in the United States. We will provide only absolutely necessary care overseas and then move the patients to the United States as soon as they are stable enough to travel. We will have sufficient aeromedical evacuation capability to implement this plan.

Our present concepts envision using civil sector backup capability only during wartime situations involving overseas combat. Planning for peacetime natural disasters is the responsibility of local and State government agencies as well as the Federal Emergency Management Agency.

The Department of Defense, like HHS and the VA, cooperates fully in the planning to meet the demands for medical care resulting from natural disasters. No natural disaster planning scenario has yet been identified, however, which would require activation of the civilian-military contingency hospital system.

This concludes my prepared statement, Mr. Chairman. I would be happy to answer any questions the committee may have regarding this matter.

Senator MURKOWSKI. Thank you, Doctor.

I think it appropriate to call on counsel for comments regarding confidentiality.

Mr. BERGQUIST. At this time, I would like to make the administrative announcements necessary in order to close the hearing. After these announcements, Senator Murkowski will recess the hearing for approximately 2 or 3 minutes until we clear the committee room.

The hearing will be closed probably no more than 10, at the most 15 minutes, and then we will reopen the hearing.

I have the list of all of those that have clearances, and I will restrict the attendance to only those individuals who have classification of top secret.

So I would ask that everyone else please leave the hearing room and take all books, handbags, packages, anything that you brought in with you, please remove it. We will have to check the hearing area.

At this time I will turn it over to Senator Murkowski for a recess.

Senator MURKOWSKI. Thank you, Ken. We will recess for a few minutes. We will reconvene after the confidential session.

[Whereupon, the hearing went into a closed session.]

[Open hearing resumed.]

Senator MURKOWSKI. I apologize to those who were inconvenienced by having to leave for a short period of time. I hope that the inconvenience was not too great.

On the other hand, you could look at it from a positive point of view, you got a little break and we didn't. But, in any event, the Chair does thank you for your patience. We will proceed.

We have Dr. John Moxley, accompanied by Lieutenant Colonel Reed and Lieutenant Colonel Burke who participated in the confidential portion of the hearing. We have a few remaining questions for those gentlemen that are not confidential and we will, therefore, proceed.

Ken, go ahead and submit your questions.

Mr. BERGQUIST. I just have one question and then I will submit additional questions that are prepared both by Senator Cranston and others.

I understand that both the VA and the Defense Department have had discussions with Senator Inouye in regard to sharing of resources since I believe both Hawaii and Alaska are the only States that do not have VA hospitals.

In addition, the Guam Legislature has petitioned this committee, the Secretary of Defense, the Administrator of the VA and others to provide for further joint use of Navy facilities for veterans that reside in Guam.

What progress has been made in planning for shared resources in these areas?

Dr. MOXLEY. The Department of Defense is currently sharing hospital facilities on Guam where three beds are utilized for VA patients. The number of beds allocated by the Department has been driven by the VA's stated requirement for beds.

We had also heard that there was a need for more and certainly if the VA decides to approach the Department with a request for additional bed allocation at the Guam facility, we will certainly support them to the extent of our capability.

I have not checked specifically with Guam. I was there, I guess, about a year ago. But my recollection is that we could go beyond the three beds, but that is a personal opinion now.

We have not, as far as I know, received any official request to look into the matter, but are certainly willing to.

As far as I know, the sharing relationship in Hawaii is working smoothly, at least there have been no problems called to Washington's attention, within my memory, which may be quite short.

I am not—I am embarrassed to say with the chairman looking at me—I am not aware of any problems in Alaska either, but I am not, I must confess, not fully conversant with the sharing that goes on up there.

Senator MURKOWSKI. OMB has announced the planned expiration of the act of 1789 which created the Marine Hospital service. I believe the total number of beds in these facilities, known now as Public Health Service hospitals, to be in the area of 2,000.

Does that sound reasonable?

Dr. MOXLEY. Yes.

Senator MURKOWSKI. I believe the DOD has some 20,000 beds?

Dr. MOXLEY. Correct.

Senator MURKOWSKI. And the VA has some high seventies; 78,000?

Dr. MOXLEY. Total beds are 89,000.

Senator MURKOWSKI. Eighty-nine?

Recognizing that the fishermen and merchant seamen that formerly utilized the facilities of the Public Health Service hospitals and also were afforded treatment in their own communities, that has been curtailed and will be eliminated. There is obviously not an adequate time allowance for them to seek either group-type coverage or other arrangements.

Would it be conceivable, in your opinion, that this sharing might include fishermen who qualify serving on documented vessels and members of the merchant marine under one of two scenarios, either under a new public law where the benefits would be continued or, if that were not possible, the likelihood of a phaseout period being provided for 1 year, or 18 months, so that they could secure private coverage and the assimilation of those 2,000 beds? I have no idea what the occupancy actually is in the hospitals, so we can assume it would be less than 2,000 beds which could be assimilated under this combined concept that we are pursuing of sharing between the DOD and the VA. Your opinion, recognizing that there are a lot of mechanics to overcome such as who pays and who administers?

Dr. **Moxley**. For the specific categories of Public Health Service—health-care systems beneficiaries that you are addressing, we have not, within the Department of Defense, to my knowledge, and I think that would encompass all of the discussions that have gone on there—explored that.

We, at the present time, have some difficulty meeting the requirements of our own beneficiary population. My guess is if we were asked to and took a hard look at it, the Department would obviously cooperate anyway it could. There would be some areas where we might for short periods of time might be able to provide some relief.

There would be others where my personal opinion would be that our system would already be so full of our own beneficiaries that we would be unable to accommodate any others.

I state that the beneficiaries that you, the public health service beneficiaries that you are talking about because the public health service, the corps itself, as has been pointed out earlier, already has the capability of using either the VA or the DOD system.

As a matter of fact, up until now with the Public Health Service system, our beneficiaries have been able to use that system also. As a matter of fact, it obviously will be our responsibility to absorb those beneficiaries that we are responsible for.

In some cases, that takes up about 25 percent of those being seen in the Public Health Service system. And of those that are left, which would be the fishermen and the merchant marine, and so forth, we have not been involved in any discussions about that.

I think that it would be difficult, but we would cooperate in any way that we could.

Senator **Murkowski**. What is the average occupancy of your 20,000-bed hospital system?

Dr. **Moxley**. I would want to provide that for the record, Mr. Chairman, if I can. I don't have it off the top of my head.

Senator **Murkowski**. Any idea? No idea what your——

Dr. **Moxley**. It runs in the neighborhood of 80 percent, but I certainly would want to refine that. I have not looked at it in the recent past.

Senator **Murkowski**. In your opinion, what would likely be the disposition of those patients in the Public Health Service hospitals when they close? What does the Federal Government do with people that are in the hospital when it closes a hospital?

Dr. **Moxley**. Well, sir, that health-care system is the responsibility of the Department of Health and Human Services, and I don't know what they are intending. They have the primary responsibility for that system.

Senator **Murkowski**. Thank you.

We have three other questions. I would like to ask your forbearance for the time is moving along rapidly and I will keep my questions shorter, too.

Dr. Moxley, the passage of this legislation would establish the VA as a primary contingency backup resource for the Department of Defense. Since a civilian military contingency hospital system currently being developed relies heavily upon the civilian hospital sector, what changes in your planning would you envision if legislation such as amendment No. 62 is enacted?

Dr. MOXLEY. The changes in planning, if it were the desire of the administration and the Congress, would not change our planning in terms of the approach that we are taking. It would not, in our judgment, diminish the requirement for us to continue planning with the civilian sector.

It would put into sequence, the sequence that we have always favored, that is, that we would look first to the DOD facilities, but that at the time that they were overrun, we would then turn to VA and then we would turn to the civilian sector.

It wouldn't be strictly tiered, but it would be in that sort of sequence. That is what the passage of this would allow.

Senator MURKOWSKI. Senate bill 266 would provide significant latitude to individual DOD facility commanders to enter into sharing agreements with the Veterans' Administration hospital directors. Do you believe that the surgeon generals of the various uniformed services would support providing such autonomy to their facility commanders?

Dr. MOXLEY. As I mentioned, we testified as a foursome last year on this legislation. All three surgeon generals were there and all three did support that aspect. They supported the bill and that was included in it.

Senator MURKOWSKI. All right. Dr. Moxley, thank you very much for your presentation before the committee. It has been most helpful and informative and we certainly thank your assistant, Lieutenant Colonel Reed and Lieutenant Colonel Burke.

You are excused, gentlemen.

Dr. MOXLEY. Thank you, Mr. Chairman.

[The responses of the Department of Defense to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF THE DEPARTMENT OF DEFENSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. On July 30, 1980, you testified before the Senate Committee on Governmental Affairs that the Department of Defense was working closely with both the Veterans' Administration and various civilian medical facilities to create sharing agreements for treatment of war casualties. How many of these agreements have been consumated, and how many casualties would the VA and civilian hospitals each be able to handle under these agreements?

Answer 1. Members of the staff of the Civilian-Military Contingency Hospital System have been meeting on a regular basis with medical planners from the office of the Chief Medical Director. To date, no agreements have been signed nor have any beds been committed for casualty care from the VA System. The VA does not feel that they currently have authority for such action.

As of 30 June 1981 there have been 113 civilian hospital agreements signed with DoD, and they have committed 6,874 beds to the contingency system. It is evident that if present trends continue, the Department of Defense will achieve its goal of a 50,000 bed minimum commitment from civilian hospitals.

Since the VA has not committed any hospital or beds to this contingency effort, DoD does not know the number of casualties that could be provided care by the VA.

Question 2. In your testimony before our Committee on June 17, you stated that "the Department of Defense favors the enactment of S. 266." Can we assume that this endorsement includes a preference for the manner in which technical points are handled by S. 266 instead of H.R. 3502, such as the date at which reimbursement would be credited?

Answer 2. Yes, the Department of Defense does believe that S. 266 in its current form is more appropriate for enactment than H.R. 3502, including the technical points you are referring to in your question.

Question 3. We would like an example, preferably from an exercise or simulation, which would show how the VA backup relates to the Civilian-Military Contingency Hospital System. How are the various facilities categorized in terms of readiness to handle casualties from conventional, chemical, and nuclear engagements? At what point is medical triage performed and how does this relate to assignment of patients? Which agency or facility would be expected to arrange or provide transportation from Air Staging Facilities?

Answer 3. The Civilian-Military Contingency Hospital System was evaluated during exercise POLL STATION in February 1981. Unfortunately, FEMA did not include the VA as a participant in this exercise; thus, the results did not completely evaluate the operation of the system. Hopefully future exercises will clearly demonstrate the VA role in casualty care.

We use nine medical categories to classify casualties. These categories are medical, psychiatry, general surgery, burn, neurosurgery, orthopedic, urology, oral/maxillo-facial, and ophthalmology. Each hospital will report its capability utilizing these categories. Appropriate sorting of these patients will occur at the airport by a combination of both military and civilian personnel as designed by the local military medical center. Patients would then be transferred to the hospital either military, VA, or civilian where the best care could be given for that particular casualty and his specific condition. The local military medical center is currently tasked with the responsibility of developing a transportation plan which would use both military and civilian vehicles for transfer to hospitals.

Question 4. You state, "Our present concepts envision using civil sector backup capability only during wartime situations involving overseas combat." Does this imply that the DoD and VA resources would be adequate and sufficiently coordinated to fully meet medical needs which might arise from an enemy attack on the continental United States?

Answer 4. No, it must be remembered that if an attack occurs on continental United States, the Federal Emergency Management Agency is given the responsibility for the planning of health care needs. Our planning has been limited to the provision of medical care for casualties resulting from a conflict outside continental United States that does not result in an attack on the United States. The design and use of a national program for health care treatment and the use of both governmental and civilian hospitals is the responsibility of FEMA. When planning does begin on such a program, the Department of Defense will be an active participant in such discussions.

Question 5. Under Executive Order 11490, all agencies of the Federal government are required to develop plans to assure that they are able to perform their essential functions "during any emergency that might conceivably occur." Are there any natural disasters, such as earthquakes, which might sufficiently incapacitate Defense Department hospitals in a limited area so that VA facilities might be needed?

Answer 5. All DoD health care facilities have appropriate disaster plans to ensure continued treatment or appropriate referral to other institutions as dictated by local disaster plans. We do not see any natural occurence such as an earthquake creating major demands on VA facilities by the Department of Defense. In this regard, DoD medical facilities have had an excellent record of full cooperation with local civilian leadership in providing care for such disaster victims.

Question 6. John W. McConnell of FEMA testified that the Department of Health and Human Services (HHS) has the assigned responsibility to develop plans and programs for mobilization of the Nation's health resources in time of national emergency. What plans have been developed by HHS for the use of Defense Department hospital beds in a "national emergency"? In this regard, is the HHS role limited to "management of the planning", or does it have a managerial function in regard to "the actual use of the Nation's essential resources likely to be required in emergencies"?

Answer 6. Mr. McConnell is correct in his statement concerning FEMA and the Department of Health and Human Services. However, the Department of Defense is not aware of any national program developed by FEMA or the Department of Health and Human Services concerning the use of health care facilities during a time of national emergency or war involving an attack on the United States. It is possible, however, that once established, the Civilian-Military Contingency Hospital System might be used by FEMA for such an eventuality. We cannot, however, comment at this time on what plans, if any, exist within the Department of Health and Human Services or FEMA.

RESPONSE OF THE DEPARTMENT OF DEFENSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. The passage of this legislation would establish the VA as the primary contingency backup resource to the Department of Defense. Since the civilian-military contingency hospital system currently being developed relies heavily upon the civilian hospital sector, what changes in your planning would you envision if legislation such as Amendment No. 62 is enacted?

Answer 1. Amendment 62, if enacted, would not result in any change in our planning. The participation of the VA as the primary contingency backup resource has been a part of our planning. Unfortunately, we have been unable to obtain any commitment of hospitals or beds from the VA. Therefore, we are unable to develop the actual procedures for involvement of veteran administration facilities in the Civilian-Military Contingency Hospital System.

Question 2. The GAO evaluation of the first "Maximus" report on contingency planning seemed to find a reluctance on the part of DoD to rely on the VA as a backup in the time of armed conflict. Do you believe that that was a fair reading of the attitude in DoD at that time, and in what ways, if any, do you think that attitude has changed since that time?

Answer 2. The reluctance to rely on VA backup developed as a result of the VA's reluctance to commit any resources to DoD in its planning effort. The VA felt that the existing legislation limits the assistance they could provide to DoD in treatment of active duty personnel during a contingency.

With the establishment of the Civilian-Military Contingency Hospital System (CMCHS), DoD has actively sought the participation of the VA in this planning effort. A staff member representing the Chief Medical Director of the VA is a member of CMCHS work group and has been involved in this planning effort. Unfortunately, the VA has not made any formal commitment to this contingency effort. In our opinion we feel that the VA will be reluctant to make a commitment until such time as appropriate legislation is passed mandating their participation.

Question 3. What role should the Department of Health and Human Services assume in the care of military casualties from an overseas armed conflict?

Answer 3. The Department of Defense has coordinated the development of the contingency hospital system with planners from the Department of Health and Human Services. Discussions have clearly indicated the Department of Health and Human Services does not have the resources to provide active casualty care, but must be included in the coordination and development of our plans.

Question 4. On page 1 of FEMA's testimony, it is stated that, with respect to a national emergency, the Department of Health and Human Services has the "assigned responsibility . . . to develop plans and programs for the mobilization of the Nation's health resources." What is the relationship between the Department of Defense and the Department of Health and Human Services in this regard?

Answer 4. It must be recognized that the Department of Defense has developed the Civilian-Military Contingency Hospital System for use during an overseas conflict. If an attack occurs on continental United States, mobilization of our nation's health care resources becomes the responsibility of FEMA and it is our understanding that it would be an assigned responsibility of the Department of Health and Human Services. The Department of Defense will participate at any time in any discussions as to a national disaster preparedness health care program if and when such planning begins.

The relationship between the Department of Defense and the Department of Health and Human Services is excellent. Both departments in conjunction with the Veterans' Administration and the Federal Emergency Management Agency are active participants in the Interagency Health, Medical and Human Services Emergency Preparedness Committee. This committee recognizes the assigned responsibility of the Department of Health and Human Services with respect to national emergencies.

Question 5. During the height of the Vietnam conflict, the VA was treating many recently wounded individuals. Did they include service members who later returned to active duty or was the population receiving VA treatment limited to individuals who had been or were in the process of being medically discharged?

Answer 5. The patients treated by the VA during the Vietnam conflict were limited to those individuals who had been or were in the process of being medically discharged from the Armed Forces.

Question 6. Amendment No. 62, which is identical to H.R. 3502, includes a provision that would authorize the Secretary of Defense to relieve any VA employee needed by the VA to provide medical care from his or her active duty obligations. Do you believe this is an appropriate authority for the purpose of ensuring continued effective functioning of the VA in such circimstances?

Answer 6. The Department of Defense opposes this portion of Amendment No.62. Members of the Reserve Components employed by the Veterans' Administration are required by law to meet all military service obligations to include their obligation to report to active duty. This is of concern to DoD since there are 9,400 Ready Reservists (including non-medical) currently working for the Veterans' Administration. The relief of these reservists would impact on our ability to medically support our combat forces.

Question 7. FEMA, in testimony prepared for the June 17 hearing, notes:

> We believe the VA has the potential capability to expand beds under extreme emergency conditions in numbers which would more likely meet all DoD needs. This has been shown in exercises.

What exercises are being referred to, and do you agree with the FEMA statement, especially with respect to "all DoD needs."?

Answer 7. The exercise referred to in the testimony of Mr. McConnell was REX-80 ALPHA. This was the mobilization exercise conducted in the fall of 1980. In discussions with the Veterans' Administration, the four-fold expansion factor was not developed by the VA. We believe that this data was provided to FEMA by the Department of Health and Human Services, but are unable to verify.

The Department of Defense does not agree with FEMA that the VA can provide all of the DoD medical needs. The key to providing medical care includes not only beds, supplies, and equipment, but also trained medical personnel. All these factors must be considered when determining the expansion capability of the VA.

Question 8. Please provide detailed comments on the provisions of Amendment No. 62 other than proposed new subsection (g) (regarding wartime contingency plans for the VA) of section 5011 of title 38, United States Code.

Answer 8. The Department of Defense recommends that section 2 (d) (1) reflect that the providing agency be reimbursed for cost of services provided, as negotiated by the directors or commanding officers of the participating health care facilities, and which are based upon guidelines previously agreed upon by the Administrator and the Secretary of Defense.

Senator MURKOWSKI. We would proceed at this time with Dr. Donald L. Custis. Dr. Custis, Acting Director and Chief Medical Director of the Veterans' Administration.

We welcome you this morning, Doctor, and look forward to your testimony, on behalf of our permanent chairman, Senator Simpson, who regrets very much that he was unable to be here today.

TESTIMONY OF DR. DONALD L. CUSTIS, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION, ACCOMPANIED BY RALPH IBSON OF THE GENERAL COUNSEL'S OFFICE, AND DR. CARL HUGHES, ASSISTANT CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES

Dr. CUSTIS. Thank you, Mr. Chairman. May I first of all introduce my two colleagues who have joined me at the table—Mr. Ralph Ibson of the General Counsel's Office and Dr. Carl Hughes, the Assistant Chief Medical Director for Professional Services.

We are here pleased to present the views of the Veterans' Administration to assist in your consideration of several legislative proposals.

The first is an amendment, No. 62, which would establish a Federal Interagency Medical Resources Sharing Committee to prescribe uniform guidelines for sharing VA/DOD health resources on a reimbursable basis, while protecting each agency's primary beneficiaries' priority access to care.

This amendment would also establish a special priority second only to that of service-connected veterans for VA hospital care, nursing home care, and medical services for members of the Armed Forces on active duty during a period of war or national emergency declared either by the President or Congress.

The second, S. 266, is a bill "to establish a Federal Interagency Medical Resources Committee to insure the most efficient and effective use of Federal direct health care resources." The purpose of this bill is to encourage and maximize DOD sharing on a reimbursable basis. Both bills before the committee today, S. 266 and amendment No. 62, address VA/DOD interagency sharing of Federal medical care resources.

Before discussing either, I would point out that the VA is strongly committed to the concept of sharing and to the particular benefits of increased interagency sharing of medical resources between the VA and DOD facilities.

As a natural outgrowth of the differing statutes and mission related to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general there are insufficient incentives and often clear disincentives for more interagency sharing.

Much of this has been attributed to differing headquarters-level reimbursement mechanisms and in some cases to insufficiency guidance in identifying sharing opportunities.

Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

Mr. Chairman, both bills before you are drafted in a similar manner and both are intended to enhance joint VA/DOD sharing. My formal testimony discusses both bills in detail and therefore I will briefly discuss the critical differences between these two bills. Mr. Chairman, in general we find the interagency sharing provisions of amendment No. 62 to be more workable and more sensitive to the needs of this agency than those of S. 266.

For example, in contrast to S. 266, which would have the effects of mandating interagency sharing wherever possible, amendment No. 62 creates a highly desirable incentive to encourage such sharing. While S. 266 does contain similar incentives, they are not problem free. S. 266 poses some potential difficulty, in our opinion.

In providing that reimbursements will be credited to the provider facility when received by the provider agency, under existing authority agencies may credit reimbursements on the billing date; the more flexibly drafted provision in amendment No. 62 sanctions the existing practice.

S. 266 would make sharing agreements operative upon agreement by facility directors subject only to subsequent revocation after submission to the agency headquarters. This provision does not allow for sufficient review at the department or central office level which we consider essential in light of the potential magnitude of the expenditures involved and the possible impact of such agreements beyond local facility itself. In view of the improvements we have made in reviewing sharing agreements, we do not believe such a provision is necessary. Amendment No. 62 contains no such requirement, and in our judgment gives the departments and the agencies involved a more appropriate means of assuring that proposed sharing activities are consistent with overall needs.

Central to achieving a health-care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The interagency sharing provisions of amendment No. 62, in our judgment, reflect the recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DOD have through their primary beneficiaries.

While the VA has long provided needed medical care or resources for active duty military members, neither our facilities nor our mission were designed to furnish health care services to military dependents. S. 266 would mandate such care under its broad definition of the term "beneficiary." Amendment No. 62 would exclude military dependents. We feel that this inclusion of military dependents in this authority is inappropriate and ill advised.

If I may digress here just for a moment, Mr. Chairman, to point out that we have, over a period of the last several years now, been experiencing an increasingly growing dilemma, namely that of increased demand and decreased resources mostly due to inflation. At the present time we have found it necessary to cap the number of our outpatient visits, our ambulatory care workload. It is currently capped I think at 15.5 million visits a year. Parenthetically, we also provide for 2½ million ambulatory care visits on a fee-for-service basis in the private sector.

We estimate at the present time our capability for ambulatory care should be at least 22 million in VA clinics. Because of that capping we are turning away certain categories of non-service-connected veterans. We do have empty hospital beds. When we recognize the need for hospitalization there should be no reason why it can't be provided promptly.

But we do know that we are not uncovering the full need for hospitalization because of the limitations on access to the system at the ambulatory care level. When one talks about a new category of beneficiary—and in this case I am off on this subject because of the issue of the military dependent—a new category of beneficiary we are only adding to the dilemma of ever-increasing demand and ever-declining resources.

Mr. Chairman, I would also point out that the functions, responsibilities, and membership of the interagency committee are more carefully established by the language of amendment No. 62. For example, the authority to establish interagency policy is clearly retained for the respective agency heads by the provisions of amendment No. 62. The language of S. 266 is not clear on this point.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. We would welcome the opportunity to build on and expand such sharing through the incentives that the interagency sharing authority in amendment No. 62 would provide.

In sum, we believe the language of that measure would satisfy the needs of both agencies and encourage and facilitate increased interagency sharing of medical resources between the Veterans' Administration and the Department of Defense.

Mr. Chairman, amendment No. 62 would also address the role the Veterans' Administration might play in planning for an actual support of the Department of Defense in time of war or national emergency. This measure would establish a mission for the VA health care system as the primary contingency support to DOD.

It would address this situation by creating a special priority for care for military personnel under circumstances established in this bill and would provide authority during such a period to permit the Administrator to contract with private hospitals for care of non-service-connected veterans in cases where delaying care would result in deterioration of a condition for which the patient has been receiving treatment or where a medical emergency exists.

Senator MURKOWSKI. Dr. Custis, if I might interrupt you, and I apologize. We are running a little bit behind. Your entire statement will appear in the record. I wonder if you would be kind enough to summarize the balance of your remarks.

Dr. CUSTIS. I apologize, Mr. Chairman. I was reading an abbreviated summary of the full statement.

Senator MURKOWSKI. I am told by the official timekeeper here that we have about doubled the estimated presentation time.

Dr. CUSTIS. In concluding then, may I just point out that we understand the role of FEMA in a national catastrophy involving CONUS-based, massive casualties. We have every intention of continuing our cooperation in planning and for participation in casualty care under FEMA direction during national disasters.

We have difficulty understanding, however, the role of FEMA and HHS in the receipt and handling of casualties from an overseas war. We submit that it would only add administrative layering to our cooperative effort with military medicine.

I think I will stop at that, Mr. Chairman, and we would be pleased to answer any questions.

Senator MURKOWSKI. Thank you, Dr. Custis.

[The prepared statement of Dr. Donald L. Custis and the Veterans' Administration's responses to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member, Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF

DR. DONALD L. CUSTIS

CHIEF MEDICAL DIRECTOR

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE

SENATE VETERANS' AFFAIRS COMMITTEE

JUNE 17, 1981

Mr. Chairman and Members of the Senate Veterans' Affairs Committee.

I am very pleased to be here to present the views of the Veterans Administration to assist in your consideration of two legislative proposals.

The first proposal, introduced as an amendment to S. 636, would establish a Federal Interagency Medical Resources Sharing Committee to prescribe uniform guidelines for sharing VA/DoD health resources on a reimbursable basis, while protecting each agency's primary beneficiaries' priority access to care. This amendment would also create a priority for care for active duty armed forces members in time of war or national emergency second only to the priority of service-connected veterans for care and treatment. The second, S. 266, is a bill "to establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources." The purpose of this bill is to encourage and maximize VA/DoD sharing on a reimbursable basis.

S. 266 would establish a Federal Interagency Medical Resources Committee, to be composed of the Secretary of Defense and the VA Administrator. The bill provides for such Committee to undertake a series of actions with a view to establishing policies applicable to both the VA and DoD with regard to the interagency sharing of medical resources. Thus, such Committee would undertake to assess opportunities for sharing Federal health resources, to include the potential for sharing in planning for additional VA or DoD medical facilities and acquisition of major new medical equipment; to identify sharing opportunities that would not adversely affect the quality or priority of care provided; and to prescribe policies and procedures to maximize VA and DoD sharing. This two-member committee would also be charged with coordinating the establishment and monitoring the implementation of uniform interagency health care policies and procedures including coordinated planning for future development of each agency's direct health care delivery system. In connection with these various duties, the bill also provides that the two member Committee shall consult, when appropriate, with other Federal providers to encourage optimum coordination in the delivery of direct health care.

S. 266 would also require that the Committee prescribe uniform guidelines to commanding officers and directors of each VA and DoD health care facility for the sharing of medical resources by such health care facilities with each other. Under those guidelines such facility heads would be mandated to enter into interagency sharing agreements whenever possible. Under such arrangements, primary direct health care beneficiaries of either the VA or DoD could receive medical care at both VA and DoD facilities. The scope of services subject to sharing could include any medical care or medical care support resources.

S. 266 provides that the availability of direct health care to VA beneficiaries at DoD facilities and to DoD beneficiaries at VA facilities would be on a referral basis. Facility directors who would negotiate such arrangements would have to determine that any such arrangements would not adversely affect the quality of care and the priority access for medical services of the providing agency's beneficiaries. Reimbursement, to be based on a determination of costs negotiated by the heads of the participating VA and DoD facilities, would be credited to the specific provider facility when received. Sharing arrangements would become operative upon agreement between facility managers, subject to disapproval by agency headquarters.

S. 266 includes caveats to the effect that the responsibilities of the Committee as to uniform direct health care should not be construed to alter the individual agencies' statutory responsibilities with regard to providing medical services, and that it would not preclude the sharing of medical resources under any other law among all Federal providers.

Last, S. 266 contains a requirement for the proposed Committee to prepare an annual report to be submitted to the Congress as a whole with regard to specific aspects of the implementation, including legislative recommendations, and to the House and Senate Appropriations Committees annually thereafter when presenting the applicable agency's appropriations request each fiscal year.

4.

Section 5 of S. 636 would mandate that the Secretary of Defense and the Administrator of Veterans Affairs direct the Assistant Secretary of Defense for Health Affairs and the Chief Medical Director respectively to form an interagency committee to assess jointly opportunities for sharing Federal health resources, to include the potential for sharing in plans for establishing additional VA or DoD medical facilities and for the acquisition of major new medical equipment, and to identify sharing opportunities that will not adversely affect the quality or priority of care provided. This bill would further require the two officials to recommend to their respective agency heads policies and procedures to maximize VA and DoD sharing of medical resources. In connection with these various duties, the bill would also require that the Assistant Secretary of Defense for Health Affairs consult regularly with the Surgeons General of the Army, Navy and Air Force.

The bill would mandate that the Administrator of Veterans Affairs and the Secretary of Defense within a year of its enactment jointly establish guidelines for the sharing of medical resources between VA and DoD medical facilities. Such guidelines would authorize VA and DoD health care facility directors to enter into cooperative sharing agreements whenever possible.

These agreements would be negotiated between the heads of the facilities concerned and would explicitly define the health care to be provided under the agreement. Under the bill's definitions, both veterans entitled to care in VA facilities and members and former members of the Army, Navy, Air Force or Marine Corps entitled to medical and dental care under title 10, United States Code, would be considered "primary beneficiaries of the respective agencies," and as such could be provided medical care under a sharing agreement.

The agreements would have to assure that the availability of direct health care for such beneficiaries is on a referral basis only, and that any such care rendered nonprimary beneficiaries would not adversely affect the range of services, quality of care, or priority access for service of the providing agency's primary beneficiaries. Reimbursement of the providing facility's costs, using any costing methodology based on the cost of service provided, would be as agreed on by the Secretary of Defense and VA Administrator, or their designees, and would be credited to the specific facility which provided the health care services.

The measure also calls for a VA-DoD annual joint report with regard to various aspects of the bill's implementation, to be submitted to the Congress as a whole at the time the President's Budget for the next fiscal year is transmitted.

Although the bill does not specifically so provide, it appears clear that the proposed joint responsibilities of the Secretary of Defense and Administrator of Veterans Affairs as to uniform direct health care are neither intended to alter VA's or DoD's statutory responsibilities with regard to providing medical services, nor to preclude the sharing of medical resources under any other law, except to the extent that it would amend 38 U.S.C. § 5011 to eliminate the authority of both the VA, and the military department heads to transfer to other "facilities, supplies, equipment or material" needed in the care of veterans without reimbursement of appropriations.

The VA is strongly committed to the concept of sharing and to the particular benefits of increased interagency sharing of medical resources between VA and DoD facilities. As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases to inefficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle. We believe that adoption of a policy directing that amounts collected be distributed to the facility that generated the reimbursement would be helpful.

Our own specific sharing authority in section 5053 of title 38, United States Code, is limited in scope to specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

7.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

Turning to the bills before you, Mr. Chairman we find the interagency sharing provisions of section 5 of S. 636 to be more workable and sensitive to the needs of this agency than those of S. 266.

For example, in contrast to S. 266, which would have the effect of mandating interagency sharing whenever possible, S. 636 creates highly desirable incentives to encourage such sharing.

While S. 266 does contain similar incentives, they are not problem-free. S. 266 poses some potential difficulty, for example, in providing that reimbursements will be credited to the provider facility when received by the provider agency; under existing authority agencies may credit reimbursements on the billing date. The more flexibly drafted provision in S. 636 would appear to sanction the existing practice.

S. 266 would also make sharing agreements operative upon agreement by facility directors subject only to subsequent revocation after submission to agency headquarters. This provision does not allow for sufficient review at the Department or Central Office level, which we consider essential in light of the potential magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself. In view of the improvements we have made in reviewing sharing agreements, we do not believe such a provision is necessary. S. 636 contains no such requirement, and in our judgment gives the Departments and agencies involved a more appropriate means of assuring that proposed sharing activities are consistent with overall needs.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The interagency sharing provisions of S. 636, in our judgment, reflect a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DoD have to their primary beneficiaries. In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

While the VA has long provided needed medical care or resources for active duty military members, neither our facilities nor our mission were designed to furnish health care services to military dependents. S. 266 could mandate such care under its broad definition of the term "beneficiary." We believe inclusion of military dependents within S. 266 is inappropriate, and opening the VA health care system to these DoD beneficiaries is ill advised.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. We would welcome the opportunity to build on and expand such sharing through the incentives that the interagency sharing authority in S. 636 would provide. In sum, we believe the language of that measure would satisfy the needs of both agencies and encourage and facilitate increased interagency sharing of medical resources between the Veterans Administration and the Department of Defense. The provisions would also maintain the integrity and separate health care missions of these provider agencies, and enhance their respective abilities to accomplish these missions in a cost-effective manner.

Mr. Chairman, S. 636 would also address the role the Veterans Administration might play in planning for and actual support of the Department of Defense in time of war or national emergency. This bill would provide a role for the VA health care system as a contingency support to DoD, and would create a special priority for care for military personnel under those circumstances. We would point out that the VA has been involved in interagency planning and preparation for emergency situations pursuant to the provisions of Executive Order (E.O.) 11490, as amended. This Order, entitled "Assigning Emergency Preparedness Functions to Federal Departments and Agencies," is based on legislative mandates concerned with national security and defense. The VA is expressly charged in Part 29 of the Executive Order to "develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veterans Administration under all conditions or national emergency, including attack upon the United States."

In considering contingency planning and support legislation, we would call attention to the possibility that a major oversees war involving U.S. military forces (and VA facilities caring for battlefield casualties and new veterans) might well involve an attack on the United States. Under such circumstances, the FEMA might be called upon to coordinate national efforts. The VA would necessarily work with FEMA and other civil agencies in such contingencies.

The contingency medical backup of the VA to the military medical system has been of historic importance. It has, however, generally involved the acceptance of military personnel recently separated for medical disabilities. Others have been accepted on a space-available basis and returned to duty status.

The military medical system currently has a manifest need for increased combat casualty support. This legislation is designed to formalize the VA's contingency mission by upgrading the priority for VA care of the active duty casualty and giving VA flexibility to enter into long-range plans with DoD to furnish various levels of support.

Whether the VA should be formally charged with this reponsibility, however, is an issue with profound implications. Thus, until such time as a new VA Administrator has had an opportunity to review this issue in coordination with the other involved agencies and departments, we are not able to take any formal position on this question. We would make a comment, however, as regards the provision of S. 636 that would authorize, without Executive branch review, requests to Congress for relief from personnel ceilings or for appropriations to carry out this emergency authority. That proposal represents an unwarranted intrusion into the prerogatives of the Executive, and, as such, we strongly object to it.

Enactment of this bill would not result in any immediate costs to the VA. Planning and testing associated with those proposals would require no additional resources, and the costs of activating the contingency system cannot be projected with any reliability until the need for these services arises.

Mr. Chairman, that completes my testimony for this morning. We will be pleased to answer any questions you or other members of the committee might have.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Senator Simpson's Question No. 1: Under current contingency plans, how would management and communication functions within the VA be decentralize if Central Office were destroyed by an enemy attack?

Answer: In the event of an enemy attack that destroyed Central Office, VA management would continue through its decentralized field facilities - both VA medical centers and regional offices. Management and communications functions would be carried out by the appropriate successor to the Administrator of Veterans' Affairs. If there were warning time, designated successors to the Administrator would relocate to emergency operation centers outside the Washington, DC, area. As communications are restored after an attack, the successor would then be able to advise the President of the management of the VA resources. In case of a surprise attack, successors to the Administrator have also been designated at VA facilities throughout the country. Each director of a VA field installation has been delegated authority to continue essential operations under emergency conditions. As communications are restored between facilities, the Administrator or his successor would take charge in accordance with documented procedures.

Senator Simpson's Question No. 2: In a wartime contingency situation, which agency would be expected to arrange or provide transportation of military casualties from Air Staging Facilities to VA hospitals?

Answer: In a wartime contingency situation, the Department of Defense would be expected to arrange or provide transportation of military casualties from Air Staging Facilities to VA medical centers. In most cases, the Department of Defense would rely upon local civilian resources for moving patients from the airheads to VA hospitals.

Senator Simpson's Question No. 3: FEMA testified that "the VA has the potential capacity to expand beds under extreme emergency conditions in numbers which would more than likely meet all DOD needs." Do you agree with this assessment, or the Defense Department's testimony that the combined capabilities of DOD and VA would be insufficient to meet the demands for hospital care which could be expected from a NATO - Warsaw Pact war?

Answer: VA strongly disagrees with the testimony provided by FEMA that "the VA has the potential capacity to expand beds under extreme emergency conditions in numbers which would more than likely meet all DOD needs." FEMA further testified that VA has a fourfold expansion capacity. FEMA's testimony was based on an erroneous assumption stemming from interagency participation in a planning exercise.

We are in agreement with the Department of Defense's testimony, that the combined capabilities of DOD and VA would be insufficient to meet the demands for hospital care which could be expected from a NATO-Warsaw Pact war. This is based upon the casualty estimates provided to us by the Department of Defense.

Senator Simpson's Question No. 4: In your prepared testimony, it is noted that "the VA has been involved in interagency planning and preparation for emergency situations pursuant to the provisions of Executive Order 11490." How has the VA been involved and what products have resulted?

Answer: Executive Order 11490 is concerned with assigning emergency preparedness functions to federal departments and agencies, including consideration of an attack upon the U.S. Part 29 of the Executive Order charges the VA to "develop policies, plans and procedures for the performance of emergency functions . . . . These include: . . . participation with the Departments of Defense and Health and Human Services as provided for in interagency agreements."

VA has worked with FEMA in describing the VA functions in the event of an attack on the U.S. These functions are presently being reviewed and updated and will be submitted to FEMA as a revision to the Executive Order in the near future.

VA has already developed specific plans for: naming successors to the Administrator; establishing emergency operations centers outside the Washington, DC, area; sending a VA representative to the Public Health Services relocation site; and naming ten VA Liaison Representatives to coordinate Regional activities with the ten FEMA Regional Directors.

Senator Simpson's Question No. 5: You point out in your prepared testimony that "FEMA might be called upon to coordinate national efforts" during an attack on CONUS. How would FEMA exercise such a role in relation to the VA? How do you distinguish among the emergency responsibilities of the VA, FEMA, and HHS?

Answer: In the event of an attack on the United States, FEMA is the lead civil defense agency for the federal government. In the area of health resources, the President has delegated primary responsibility to the Department of Health and Human Services. VA is charged to coordinate its resources with HHS to provide a consistent national response to health needs throughout the country.

Senator Simpson's Question 6: In view of the expressed interests of Senator Inouye and the Guam Legislature, what progress has been made in sharing resources for the Pacific Basin?

Answer: In this context sharing resources involves primarily utilization of military health care facilities by the VA for treatment of veterans. No VA health care facilities or resources are available to share with the Department of Defense in the Pacific Basin. In addition to the U.S. Army facilities utilized in Honolulu for treatment of veterans, a three-bed allocation has been set aside at the U.S. Naval Regional Medical Center on Guam for treatment of veterans residing in that area. This quota is based on past experience and demand for care. It may be adjusted upward or downward, depending on need. We also provide care by contract to eligible U.S. veterans in the Guam Memorial Hospital. A recent review of the needs of veterans residing on Guam did not disclose any serious problems that are not being resolved or met, however, the VA is planning a thorough review and evaluation of the health care needs of U.S. veterans residing on Guam to include the current methods of providing these services.

Senator Simpson's Question No. 7: We are concerned about the readiness of VA physicians to treat large numbers of battlefield casualties from either chemical or nuclear engagements. Although many of the VA physicians have had military experience, not all of this has been in treating combat casualties, and none of them have cared for survivors of a nuclear attack. In your testimony, you refer to "a highly skilled cadre of physicians, people who teach such courses." Do you feel there is an adequate current knowledge base for the treatment and management of survivors of a chemical or nuclear attack? Would the "refresher course" you mentioned be adequate, or would there have to be a program of more basic instruction? How many VA physicians are currently prepared to handle such responsibilities?

Answer: Yes, there is an adequate knowledge base for the treatment and management of survivors of a chemical or nuclear attack. After decontamination of casualties of chemical or nuclear attack, the treatment of those cases is dependent upon the various forms of medical or surgical care as indicated by the type of damage sustained. These capabilities are available in any VA hospital that would be designated to receive cases. For example, there are 130 nuclear medicine services in the VA system, each with a trained staff.

The "refresher courses" are excellent, detailed courses of instruction which are most adequate. Appropriate personnel have and will continue to be detailed to attend them. They are given by the Medical and Health Sciences Division, Oak Ridge Associate Universities, Oak Ridge, Tennessee.

Presently, there are 138 physicians in the VA system that are trained nuclear medicine specialists who can supervise the management of radiation sickness. The casualties from nuclear attack due to heat and blast effects and those suffering traumatic injuries due to exposure to chemicals would be cared for by the 2,244 surgeons and 4,115 internists in the VA.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Senator Cranston's Question No. 1: Based on your personal experiences in both the VA and the Navy, do you have a personal view of the need for the provisions of S. 266 and my Amendment No. 62?

Answer: I feel very strongly that sharing legislation that establishes a clear mandate to share; provides for equitable rate setting to be used for exchange of services; provides for streamlining of reimbursement procedures; and at the same time, provides protection for each agency's beneficiaries and maintains each agency's control over its mission and management is desirable. It is my personal opinion, as well as the position of the Agency, that Amendment No. 62 with minor amendments would meet the above criteria much more effectively than would the provisions of S. 266.

Senator Cranston's Question No. 2: As between the approach to peacetime sharing with DOD, do you personally favor the approach in S. 266 or in Amendment No. 62, and why?

Answer:

I personally favor the approach in Amendment No. 62.

Senator Cranston's Question No. 3: Have you prepared a detailed analysis of S. 266 vs. the provisions of Amendment No. 62, and, if so, would you please share that analysis with the Committee?

Answer: Some weeks ago, my staff drafted an analysis comparing the provisions of S. 266 vs. the provisions of H.R. 3502. This analysis was simply an internal working draft which did not necessarily reflect the views of the VA, and would serve no useful purpose.

VA has submitted reports to the Congress on both S. 266 and H.R. 3502, which is identical to your Amendment No. 62, stating vi[illegible] both bills. I am attaching copies of these reports, and will be happy to provide fur[illegible] explanations of our views.

SEP 24 1981

Honorable Melvin Price
Chairman, Committee on
Armed Services
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the VA on H.R. 3502, a bill "To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense."

The major purpose of this bill is to encourage and assist greater sharing of medical resources between the VA and the Department of Defense in order to benefit the primary beneficiaries of both agencies and which could result in reduced costs to the government. At the same time, it would also create a priority for care for active duty armed forces members in time of war or national emergency second only to the priority for service-connected veterans for care and treatment. Subject to several revisions discussed below, the VA favors the enactment of the provisions of this bill.

H.R. 3502 would mandate that the Secretary of Defense and the Administrator of Veterans Affairs direct the Assistant Secretary of Defense for Health Affairs and the Chief Medical Director respectively to form an interagency committee to assess jointly opportunities for sharing health resources between the VA and the DoD, to keep each other apprised of plans for establishing additional VA or DoD medical facilities and for the acquisition of major new medical equipment, and to identify sharing opportunities that will not adversely affect the quality or priority of care provided. This amendment would further require the two officials to recommend to their respective agency heads policies and procedures to maximize VA and DoD sharing of medical resources. In connection with these various duties, the amendment would also require that the Assistant Secretary of Defense for Health Affairs consult regularly with the Surgeons General of the Army, Navy and Air Force.

2.

Honorable Melvin Price

H.R. 3502 would mandate that the Administ ator of Veterans Affairs and the Secretary of Defense within a year of its enactment jointly establish guidelines for the sharing of medical resources between VA and DoD medical facilities. These guidelines would authorize VA and DoD health care facility directors to enter into cooperative sharing agreements whenever possible.

Under the guidelines, these agreements would be negotiated between the heads of the facilities concerned and would explicitly define the health care to be provided under the agreement. Under the amendment's definitions, both veterans entitled to care in VA facilities and members and former members of the Army, Navy, Air Force or Marine Corps entitled to medical and dental care under title 10, United States Code, would be considered "primary beneficiaries of the respective agencies," and as such could be provided medical care under a sharing agreement.

The agreements would have to assure that the availability of direct health care for such beneficiaries be on a referral basis only, and that any such care rendered nonprimary beneficiaries would not adversely affect the range of services, quality of care, or priority access for service of the providing agency's primary beneficiaries. Reimbursement of the providing facility's costs, using any costing methodology based on the cost of the service provided, would be as agreed on by the Secretary of Defense and VA Administrator, and would be credited to the specific facility which provided the health care services.

The measure also calls for a VA-DoD annual joint report with regard to various aspects of the bill's implementation, to be submitted to the Congress as a whole at the time the President's Budget for the next fiscal year is transmitted.

Although the bill does not specifically so provide, it appears clear that the proposed joint responsibility of the Secretary of Defense and Administrator of Veterans Affairs as to uniform direct health care is neither intended to alter VA's or DoD's statutory responsibility with regard to providing medical services, nor to preclude the sharing of medical resources under any other law, except to the extent that it would amend 38 U.S.C. § 5011 to eliminate the authority of both the VA and the military department heads to transfer to the other "facilities, supplies equipment or material" needed in the care of veterans without reimbursement of appropriations.

The VA is strongly committed to the concept of sharing and to the particular benefits of increased interagency sharing of medical resources between VA and DoD facilities. As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases, to inefficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

The Agency believes that distributing the amounts collected to the facility that generated the reimbursement would be helpful. The VA has specific authority in section 5053 of title 38, United States Code, to share specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

The Agency finds the interagency sharing provisions of H.R. 3502 to be workable and sensitive to the needs of the VA, creating highly desirable incentives to encourage such sharing.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The interagency sharing provisions of H.R. 3502, in our judgment, reflect a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DoD have to their primary beneficiaries. In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. The VA would welcome the opportunity to build on and expand such sharing through the incentives that the interagency sharing authority in the bill would provide. In sum, the VA believes the language of that measure would satisfy the needs of both agencies and encourage and facilitate increased interagency sharing of medical resources between the Veterans Administration and the Department of Defense. The provisions would also maintain the integrity and separate health care missions of these provider agencies, and enhance their respective abilities to accomplish these missions in a cost-effective manner.

The VA has long provided needed medical care or resources for active duty military members, but neither our facilities nor our mission were designed to furnish general health care services to military dependents. While the VA could, under existing authority, furnish scarce medical services to any DoD beneficiary under a sharing agreement, we would oppose any proposal which would open the VA health care system at large to military dependents.

In essence, VA supports enactment of the sharing provisions of H.R. 3502 so long as any such legislation does not extend VA medical services to military dependents. Enactment of those provisions would not result in any costs to the VA.

H.R. 3502 would also formalize the role the Veterans Administration might play in planning and providing actual support for the Department of Defense in time of war or national emergency. This measure would establish a special priority for VA hospital care, nursing home care, and medical services for members of the Armed Forces on active duty during a period of war or a period of national emergency declared either by the President or the Congress. This priority would be second only to the priority of service-connected veterans for care and treatment.

It would also provide special contract authority during such a period of war or national emergency to permit the Administrator to furnish (1) hospital care for veterans currently receiving outpatient medical services under subsections (f) and (g) of section 612 of title 38, United States Code, if delay in furnishing such hospital care would be likely to result in deterioration of the veteran's condition, and (2) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing the care or services required because of furnishing care to members of the Armed Forces under this new authority.

H.R. 3502 would provide for DoD reimbursement to the VA at rates agreed upon by the Administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursements to the VA would be credited to the appropriations available to the VA facility providing the care or service. The measure also makes provision for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable), to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

The measure would also direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

The contingency medical backup of the VA to the military medical system has been of historic importance. It has, however, generally involved the acceptance of military personnel recently separated for medical disabilities. Others have been accepted on a space-available basis and returned to duty status.

The military medical system currently has a manifest need for increased combat casualty support. This provision is designed to formalize the VA's contingency mission by upgrading the priority for VA care of the active duty casualty and giving VA flexibility to enter into long-range plans with DoD to furnish various levels of support.

The VA strongly supports the desirability of medical contingency planning between the Department of Defense and this Agency. Requirements in the law that VA facilities be maintained to ensure their availability for the treatment of the veteran, and that preference in providing medical services be given to various classes of veterans have, however, prevented us from committing the Agency to specific plans for participation in a civilian-military contingency hospital system.

6.

Honorable Melvin Price

Interagency agreements were signed with DoD in 1965 and with DHEW (DHHS) in 1972 to coordinate planning and mutual support roles. The agreement with DoD established policies and directed planning to utilize VA facilities for military patients in support of a national emergency when the United States is not under attack. The agreement with DHEW was designed to ensure the maximum utilization of VA health resources following an attack "upon the United States" and to facilitate developing joint emergency operating plans and procedures.

Within the last two years, efforts have been made to review and update these two agreements and to establish operating procedures and coordinating systems. The need for this action has been made apparent in recent joint military civilian readiness exercises sponsored by the Federal Emergency Management Agency (FEMA).

While the VA has embarked on preliminary discussions with DoD to determine how our resources could best be utilized in a support role, we believe that legislation such as H.R. 3502 would be needed to assure that VA could provide meaningful support to the Department.

Providing priority care to military personnel under such a contingency would necessarily displace certain eligible nonservice-connected veterans temporarily from access to care at VA medical centers involved in this effort. Although the VA does not favor the denial of care to any eligible veteran at any time, H.R. 3502 draws a reasonable line in providing the agency contract authority to assure continuity of care for those veterans under treatment and for others in need of emergency care. We believe that the limited exercise of this contract authority would be justified during a period of war or national emergency. The Agency believes military casualties should have a high priority claim on the limited VA resources that could be available at such a time. Accordingly, we believe special contract authority would permit the agency to respond flexibly in such an emergency situation.

The proposed new section 5011(g)(1) would empower the President to authorize the Administrator to extend higher priority for treatment to "members of the Armed Forces on active duty" than to other eligibles except veterans with service-connected disabilities. We understand this broader language to reflect an intention to leave to the Administrator and Secretary of Defense determinations as to the kinds of medical cases to be referred to the VA. Such determinations would be addressed in detailed guidelines to be developed under this proposal.

While we favor legislation to meet the purposes of H.R. 3502, we oppose the following two provisions and urge their deletion. We strongly oppose proposed new section 5011(g)(4), which would authorize, without Executive branch review, requests to Congress for relief from personnel ceilings or for appropriations to carry out this emergency authority. That proposal represents an unwarranted intrusion into the prerogatives of the President and the Executive Branch. This Administration and any Administration would request on a swift and timely basis any additional funds or personnel necessary to meet emergency requirements. We also oppose the provision which would authorize the Secretary of the military department concerned, during the period of war or national emergency, to relieve VA employees whose duties concern the furnishing of care and services under chapter 17 of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform.

Enactment of the provisions of H.R. 3502 would not result in any immediate costs to the VA. Planning and testing associated with this proposal would require no additional resources, and the costs of activating the contingency system cannot be projected with any reliability until the need for those services arises.

The Office of Management and Budget has advised that there is no objection to the presentation of this report and that enactment of proposed new section 5011(g)(4) would not be in accord with the President's program.

Sincerely,

ROBERT P. NIMMO
Administrator

SIGNED AND DISPATCHED
SEP 24 1981
ADMINISTRATOR'S OFFICE

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Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MAY 20 1981

Senator William V. Roth, Jr.
Chairman, Governmental
Affairs Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

We are pleased to respond to your request for the views of the VA on S. 266, a bill "To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources."

S. 266 is intended to clarify, and to some extent enlarge upon the authority of the Veterans Administration (VA) and the Department of Defense (DoD) to share medical resources and thereby facilitate and encourage the interagency sharing of medical care and medical care support resources.

The bill would establish a Federal Interagency Medical Resources Committee, to be composed of the Secretary of Defense and the VA Administrator. The bill provides for such Committee to undertake a series of actions with a view to establishing policies applicable to both the VA and DoD with regard to the interagency sharing of medical resources. Thus, such Committee would undertake to assess opportunities for sharing Federal health resources, to include the potential for sharing in planning for additional VA or DoD medical facilities and acquisition of major new medical equipment; to identify sharing opportunities that would not adversely affect the quality or priority of care provided; and to prescribe policies and procedures to maximize VA and DoD sharing. This two-member committee would also be charged with coordinating the establishment and monitoring the implementation of uniform interagency health care policies and procedures, including coordinated planning for future development of each agency's direct health care delivery system. In connection with these various duties, the bill also provides that the two member Committee shall consult, when appropriate, with other Federal providers to encourage optimum coordination in the delivery of direct health care.

The bill would also require that the Committee prescribe uniform guidelines to commanding officers and directors of each VA and DoD health care facility for the sharing of medical resources by such health care facilities with each other. Under those guidelines such facility heads would be mandated to enter into interagency sharing agreements whenever possible. Under such arrangements, primary direct health care beneficiaries of either the VA or DoD could receive medical care at both VA and DoD facilities. The scope of services subject to sharing could include any medical care or medical care support resources.

The bill provides that the availability of direct health care both to VA beneficiaries at DoD facilities and to DoD beneficiaries at VA facilities would be on a referral basis. Facility directors who would negotiate such arrangements would have to determine that any such arrangements would not adversely affect the quality of care and the priority access for medical services of the providing agency's beneficiaries. Reimbursement, to be based on a determination of costs negotiated by the heads of the participating VA and DoD facilities, would be credited to the specific provider facility. Sharing arrangements would become operative upon agreement between facility managers, subject to disapproval by agency headquarters.

The bill includes caveats to the effect that the proposed joint responsibilities of the Committee as to uniform direct health care should not be construed to alter the individual agencies' statutory responsibilities with regard to providing medical services, and that it would not preclude the sharing of medical resources under any other law among all Federal providers.

Last, S. 266 contains a requirement for the proposed Committee to prepare an annual report to be submitted to the Congress as a whole with regard to specific aspects of implementation, including legislative recommendations, and to the House and Senate Appropriations Committees annually thereafter when presenting the applicable agency's appropriations request each fiscal year.

Congress had the foresight to recognize the utility of the sharing concept for the VA medical care system in the early 1960's. Public Law 89-785, enacted in November 1966, gave the Veterans Administration specific statutory authority to enter into agreements to receive from and share with medical schools, hospitals, and research centers throughout the country the most advanced medical technology, information, and certain specialized medical resources. This authority was intended to improve the quality of hospital care and other medical services provided veterans by authorizing the Administrator to receive and share specialized medical resources without diminution of services to veterans. Congress also had given the Secretaries of the military departments and the VA Administrator authority, with some exceptions, to enter agreements for the mutual use or exchange of use of hospital and domiciliary facilities, equipment and supplies, and for the transfer among them of these items without reimbursement (38 U.S.C. § 5011), but this authority was seldom if ever invoked.

Veterans Administration sharing activity has grown dramatically. The number of sharing contracts has increased 15 times since enactment of sharing authority 14 years ago. In 1967, only 15 VA hospitals had agreements to share specialized medical resources under section 5053 of title 38, U.S.C.; those 15 agreements had a total monetary value of services bought and sold of $118,875. In 1979, there were 99 VA medical centers having 240 sharing contracts for a total value of services exchanged amounting to $20,198,677. Sharing has been beneficial not only to the VA, but to the community as well. Additionally, new items and new services have been added each year since this sharing law was enacted. The sharing agreements have resulted in better cooperation between VA hospitals and their community counterparts, and in better utilization of medical specialists, technologies and facilities.

Together with our sharing efforts with community facilities, VA has enthusiastically sought increased cooperation among Federal medical systems. The VA has for many years been in the forefront among Federal agencies in initiating "cross-servicing" agreements under the Economy Act. The VA currently has 64 active field facility cross-servicing medical service and research agreements, 23 such agreements between VA Central Office and other Federal agency headquarters, and 18 active agreements to procure medical supplies with other Federal agencies in the interest of economy. These Veterans Administration agreements involve other Federal agencies such as the Departments of Health and Human Services, Defense, Justice, and Energy, and the Office of Personnel Management, NASA, and the Federal Aviation Administration. We believe our extensive activities in this area evidence our commitment to the sharing of Federal medical resources, thereby facilitating medical care cost efficiency.

As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases to insufficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle. We believe that adoption of a policy directing that amounts collected be distributed to the facility that generated the reimbursement would be helpful.

Our own specific sharing authority in section 5053 of title 38, United States Code, is limited in scope to specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

In addition, the VA has played an important role in developing greater coordination in health services planning by Federal agencies through its role on the Federal Health Resources Sharing Committee. Initial interagency meetings in August and September 1977 to explore joint Federal planning and sharing of specialized medical resources culminated in the formal establishment of the Federal Health Resources Sharing Committee in February 1978. The committee (FHRSC), whose members represent the Air Force, Army, Navy, DoD, Public Health Service and the VA, has met more than 15 times. In order to respond effectively to the findings and recommendations of the Congress, OMB and GAO, the Committee has to date established six subcommittees. They have made progress in developing guidelines and criteria for assessing and justifying the need for, and appropriate location of, particular specialized medical services, in developing program utilization standards, and in actively exploring sharing opportunities in specific geographic areas.

The VA strongly supports the goal of achieving increased interagency cooperation in the use of Federal medical resources. We also applaud the development of incentives to increase sharing, particularly the bill's provision that would credit reimbursement to the specific facility which provided the medical service. The proposed legislation represents one means of encouraging an important goal.

Congress has charged the VA with providing a broad array of medical services to care for and treat veterans suffering from service-incurred and other disabilities. The VA health care system represents a commitment to the promise of quality care for veterans. In reviewing the proposed Federal Interagency Medical Resources Sharing and Coordination Act of 1981, we must consider whether this proposed attempt to achieve improved efficiency and economy would also serve the veteran, or conversely whether it would damage the system upon which the veteran has relied, and deprive the veteran of promised quality VA care.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The draft bill reflects a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DoD have to their primary beneficiaries.' In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

While the VA has long provided needed medical care or resources for active duty military members, neither our facilities nor our mission were designed to furnish health care services to military dependents. The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. We would welcome the opportunity to build on and expand such sharing through the incentives this bill would provide.

While we have focused primarily on the very broad issues raised by this bill, we have several concerns which should not escape attention. One is the provision that would appear to make sharing arrangements operative upon agreement by facility directors, subject only to subsequent revocation after submission to agency headquarters. We believe this provision may not allow sufficient review at the Department or Central Office level which we consider essential in light of the potential magnitude of the expenditures involved and the possible impact of such agreements beyond the local facility itself. We have made considerable progress in streamlining the process of reviewing sharing agreements and do not believe such provision in the bill is prudent or needed.

Secondly, we recommend that the legislative history should make clear that the uniform policies and procedures required by Sec. 4(a)(4) and Sec. 4(e)(5) of the bill to be prescribed by the two member committee jointly should be subject to ratification by each of the agency heads involved. Similarly, we believe that the uniform guidelines to be prescribed by the Committee under section 4(a)(7) should likewise be subject to ratification by each of the agency heads involved.

In sum, we favor the principle of interagency sharing of medical resources by the VA and DoD. Such sharing would tend to enhance their respective abilities to meet their missions in a cost-effective manner. With suitable changes and clarification to insure a permissive approach to interagency sharing, we would be pleased to support this bill.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

RUFUS H. WILSON
Acting Administrator

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ADMINISTRATOR'S OFFICE

Senator Cranston's Question No. 4: In a letter to me, dated May 22, with respect to current DM&S activity regarding the civilian-military contingency hospital system, you stated:

A joint task force of representatives from VA, DOD, FEMA, DHHS, and PHS have been meeting monthly since August 1980 to improve interagency coordination and planning for the delivery of health services in local and national emergencies.

a. What is the impetus for these meetings?

b. What overall objectives is this group pursuing?

c. Who represents the VA at these meetings?

d. To whom does the task force report its progress and recommendations?

e. What specific results, if any, has the task force achieved?

f. Do you believe that a Congressional mandate, such as in Amendment No. 62, would improve the productivity of such a group of VA DOD representatives?

g. To your knowledge, has this group taken a position on the legislation under consideration in this hearing or the need for further legislation on the issues before the Committee in this hearing?

Answer:

a. The monthly meetings of the Joint Task Force are to discuss health planning issues which each of our agencies is presently pursuing. We are all involved in many of the same planning issues and by having these meetings, we are able to share our views and to coordinate our plans. The purpose of the meetings, as defined by the committee, is to: (1) develop and/or improve coordination of the federal effort in the area of public health, medical and human services emergency preparedness; (2) collaborate on implementing procedures to execute interagency agreements required under Executive Order 11490 and other appropriate planning documents; (3) complement the military readiness planning responsibilities of the Department of Defense for the overall national preparedness posture; and (4) determine objectives for coordination between federal agencies on specific emergency preparedness issues.

b. The Task Force established several objectives to be accomplished, and some of these include: (1) a review and update of interagency agreements on emergency preparedness; (2) review of plans and progress for the Civilian-Military-VA Contingency Hospital System; and (3) development of a federal response to a catastrophic disaster such as a California earthquake, or a nuclear accident.

c. The VA representatives at these meetings are: Mr. Richard Citron, the Emergency Planning Officer for the Department of Medicine and Surgery, and Mr. Robert Rosenberry, Director, Emergency Management Staff of the Office of the Administrator of Veterans Affairs.

d. The Task Force is a work group or forum for discussing issues of common interest among federal emergency health planners. Progress reports and recommendations are not officially made by this Task Force. The group is chaired by a representative from FEMA who, when a consensus is developed, may initiate formal interagency coordination through established channels.

e. The Task Force has completed a review of the numerous interagency agreements, also called Memorandums of Understanding among the federal agencies concerned with emergency preparedness in the health area. Out of this review, several suggestions and recommendations were made between the various representatives for updating and improving these agreements. Progress is now underway by each agency to update their own agreements. Another specific task accomplished by the group has been the development of a concept paper on how health resources could be mobilized to respond to a catastrophic disaster, such as a California earthquake. This paper described resources coming from Department of Defense, Veterans Administration, and Public Health Service, and linking these with local health resources to provide emergency medical care in the event of a disaster of extremely large proportions. Also, increased cooperation in planning and readiness exercises has been effected through briefing sessions.

f. A congressional mandate, such as in Amendment No. 62, is necessary.

g. This Task Force does not have the authority to take an official position on the legislation under consideration.

Senator Cranston's Question No. 5: In that same letter, you noted that members of your staff have been meeting "regularly with DOD health planners for the purpose of designing linkages and operational plans for VA participation in the civilian-military contingency hospital system."

a. How frequent are these meetings?

b. Who represents the VA at these meetings?

c. When you speak of "linkages" for the VA with the CMCHS, are these linkages only with DOD or is the VA involved in the planning civilian hospitals as well?

d. Is there an overall goal or objective for these meetings?

e. Please provide, as soon as possible for the record of this hearing, progress reports from the meetings held to date?

Answer:

a. Since January of this year, the Director of the Civilian-Military Contingency Hospital System, Mr. James Doherty, has invited the Department of Medicine and Surgery's Emergency Planning Officer to attend meetings of his "working group" to develop plans for the Contingency Hospital System. The meetings have been held monthly or more often as the need arises. The working group is comprised of Mr. Doherty and his staff plus representatives from the Army, Air Force, and Navy.

b. The VA representative has been Mr. Richard Citron.

c. When we speak of linkages for the VA with the CMCHS, we are speaking primarily of linkages between DOD and VA and not civilian hospitals.

d. The basic objective for these meetings is to share information on the progress being made by the various planners in developing the contingency hospital system. The various planners being representatives of the Army, Navy, Air Force, and the Veterans Administration.

e. No records of these meetings were documented therefore, we are unable to provide you with [illegible] progress reports from these meetings. However, a number of issues concerning the VA have been discussed, such as: the potential role of the VA medical center director in working with the military hospital commander in setting up the contingency hospital system in a designated area; the potential role of the VA in staffing and directing the sorting team which meets the arriving casualties and directs them to the appropriate local hospital; and the possible use of VA's strong affiliation program with university hospitals.

Senator Cranston's Question No. 6: On an average day, how many VA general medical care beds could be immediately made available to treat casualties from an overseas armed conflict?

Answer: It is very difficult to provide a specific answer to that question at this time. In order to arrive at a number of general medical beds the VA could make immediately available to treat military casualties, several issues must be thoroughly investigated and reviewed prior to being able to commit ourselves to any planning bed numbers. We are currently proceeding to identify these issues and investigate them so that we can assess the VA bed capacity for supporting the contingency hospital system. Some of these issues and assumptions are:

a. That the VA has the legislative authority to admit active duty personnel on a priority basis -- second only to service-connected veterans.

b. The availability of beds would be evaluated in the context of phasing-in beds over a period of time. For instance, if the VA is given about 48 hours advance notice that casualties will be arriving, then VA (and civilian hospitals) would be able to make beds available by postponing elective surgery, discharging patients to ambulatory care when medically feasible, and possibly expanding bed capacity on a temporary basis. Also, care for many VA patients may be shifted to more remote VA hospitals which are not immediately accessible to arriving casualties.

c. The location of distribution points (designated airports) has resulted in a substantial number of VA hospitals being initially excluded from the estimate because they are too far away from the key cities where casualties would be arriving. Examples include Mountain Home, TN; Asheville, NC; Iron Mountain, MI; Boise, ID, etc. Many VA medical centers are close to a metropolitan area, but too far away to make initial regulation and transportation of patients practical.

d. We do not yet know with any precision how a call-up of Ready Reservists would affect VA's operations. Nationally, about five percent of VA's manpower is in the Ready Reserve. If a mobilization took place, the loss of VA physicians and nurses could cause VA to close hospital beds and services temporarily. The extent of this impact must be assessed by each VA medical center.

Senator Cranston's Question No. 7: What role, if any, do you see the VA's psychiatric facilities serving in the event of the VA having to provide resources in time of armed conflict?

Answer: Psychiatric casualties are a substantial percentage of all military casualties. In addition, psychiatric casualties frequently develop in the bootcamps and other primary indoctrination and training facilities of the military departments. Psychiatry would play a role in providing consultation services to medical and surgical services, emergency assessment in the emergency room, operation of mental hygiene clinics and inpatient therapy for acute psychotic reactions and follow-up treatment as arranged in collaboration with the designated military unit.

Senator Cranston's Question No. 8: S. 266 would provide a very significant degree of flexibility to local facility directors, in both DOD and the VA, to develop, execute, and implement sharing agreements. Based on your experience as the former Surgeon General of the Navy and now as the VA's Chief Medical Director, do you foresee any difficulties arising in the exercise of the type and extent of local flexibility that S. 266 would provide?

Answer: In earlier requests for comments we did not agree with this provision. Until sufficient experience has been gained in developing, executing and implementing sharing agreements they should have Central Office approval before becoming operative. We also stated earlier that with the rather stringent conditions imposed for planning, developing, providing guidelines and furnishing detailed reports to Congress it would be best to retain the authority for final approval in Central Office.

Senator Cranston's Question No. 9: What are your personal views regarding the appropriate roles of FEMA and the Department of Health and Human Services for the care and treatment of battlefield casualties from an overseas armed conflict?

Answer: In a literal sense, FEMA and the Department of Health and Human Services would not be directly involved in the care and treatment of battlefield casualties from an overseas armed conflict. However, any conflict large enough to generate the number of casualties that would necessitate activating the contingency hospital system would have serious implications for the national health resources, and FEMA and HHS would then be very much involved and interested. For instance, a draft of physicians into the military would deplete the availability of physicians services to the civilian population, and in some areas this could be quite serious. Therefore, HHS would need to be consulted on which personnel should be drafted. Also, since an overseas armed conflict might eventually lead to an attack on the U.S., FEMA, HHS and other federal agencies would need to improve the readiness of the nation. Therefore, we believe that if the contingency hospital system had to be activated, it is likely that there would be considerable demand for health personnel and resources, and that FEMA and HHS would probably become involved in a resource allocation process.

Senator Cranston's Question No 10: What are your personal views regarding the role of the VA in support of the Department of Defense during periods of war or national emergency?

Answer: As you know, I have gone on record publicly many times in favor of the Department of Medicine and Surgery serving as the primary health care backup to the Department of Defense.

An excellent opportunity exists to develop an effective and available contingency medical system within the federal community by giving VA responsibility for assisting DOD in developing plans for and providing care to wartime casualties.

VA and DOD share a common interest and, to some extent, an overlap of responsibility for patients arising from warfare. If DOD lacked hospital capability, it could be forced to expedite processing and transfer of patients to VA. Consequently, the number of beneficiaries coming to the VA could rise substantially in a limited war. Thus, it is very much in the interests of both VA and DOD to consider jointly and to plan for the delivery of health care services under the contingency of limited war.

Senator Cranston's Question No. 11: Again, from your perspective as having been on both the DOD and VA sides of the fence, do you believe there are existing statutory barriers to increased sharing -- that good people with the best of intentions have been stymied by legislation that does not permit sharing -- or is the problem that, at least in part, parochial interests at work in both VA and DOD have tended to discourage sharing?

Answer: The barrier that hinders effective sharing among federal health care providers is in large measure the lack of incentives to share. A measure that provides a statutory incentive such as authorizing reimbursement to the providing facility for the cost of services provided could be expected to stimulate increased sharing.

Sharing under the Economy Act (31 USC 686) is limited to existing excess capacity. Accordingly, the Economy Act would not necessarily encourage interagency sharing in the context of agencies developing and implementing future plans.

Also, sharing by authority of title 38 USC, section 5051-53, is limited to "specialized medical resources." This statutory provision precludes the consideration of sharing of many hospital resources that would be effectively shared. The expansion of authority in this regard would enhance the scope and effectiveness of our sharing program.

Senator Cranston's Question No. 12: Do you have any estimate of the anticipated demand that would be placed on the VA by active duty DOD personnel for both in- and out-patient care in areas of the country where there is a military presence with only limited health-care facilities?

Answer: We do not know at this time, nor can we anticipate what demand would be placed upon the VA for treatment of DOD personnel. This would require an analysis of those areas of the country where military facilities are located in relation to the existence of VA facilities. This would of necessity become part of any implementing action.

Senator Cranston's Question No. 13: I understand that there is a U.S. naval hospital on Guam that is significantly underutilized while, at the same time, there is a substantial veteran population that receives health care through the VA on a contract basis. Please describe any efforts underway at present to open this DOD facility further to eligible veterans.

Answer: On Guam, the U.S. Naval Medical Center has allocated three beds for treatment of veterans who reside in the area. This allocation is based on the existing needs of the veterans and on past experience of demand for care. It is subject to adjustment if the need exists. During FY 1980, there were 19 veteran admissions to the Naval Medical Center and 10 admissions to the Guam Memorial Hospital, under contractual agreements. As a result of this distribution of veteran care needs, we have not yet concluded that an increased allocation of beds from the DOD is needed. In this regard, the VA is planning a thorough review and evaluation of the health care needs of U.S. veterans residing on Guam to include the current methods of providing these services.

Senator Cranston's Question No. 14: The American Legion, on page 4 of its testimony, states there "are major differences in the way health care is delivered between military and veterans hospitals." Please comment on that observation.

Answer: There are no major differences in the way health care is delivered between military and veterans hospitals. Each patient in both systems is evaluated and treated on an individual basis according to current state of the art practices and technology. In fact, VA and military health care facilities have many sharing agreements to conserve resources and provide high-quality care. Both health care delivery systems are based on the complementary blending of clinical care, research and educational components, which is in total consonance with the national civilian medical concept for the optimal delivery of health care.

There are, however, definite differences in the missions, entitlements to care, and patient population characteristics between the two systems. The mission of the DOD health care program is primarily to maintain the health of military personnel. The military health care programs were not designed to provide a continuum of all levels of care from acute care to care for the chronically disabled. By contrast, the VA health care system has the mission of providing comprehensive health care services for all levels of veteran patient need from acute to chronic, rehabilitative, and nursing home care.

Senator Cranston's Question No. 15: Also, please comment on the Legion's recommendation (again on page 4 of its testimony) that the Federal Interagency Medical Resources Committee, proposed to be established by S. 266 --

> ". . . should consist of the Chief Medical Director of the VA, and the Surgeons General of the separate military services. The reason for this is that these officers are best able to develop agreements and arrangements based on their individual capabilities systemwide, the availability of specific resources, and operating from an intimate knowledge of these elements. Such an arrangement would not only be more effective, but would complete and implement its work more expeditiously."

Answer: We agree that the composition of the committee at the departmental or Assistant Secretary level is desirable. Obviously, such a group could only furnish general guidance and policy provisions to a more practical working group with a delegation of authority to carry out the provisions of the act.

Senator MURKOWSKI. There are some questions that have been submitted that I will ask you.

Has the implementation of expensive new technologies forced sharing of resources even without legislation? Do we have to have legislation to share these new technologies?

Dr. CUSTIS. At the present time we have authority to share special medical programs. Most new, expensive technologies are part and parcel of such special medical programs, if I understand your question.

Senator MURKOWSKI. So you don't feel we need legislation to dictate it be shared?

Dr. CUSTIS. No, sir.

Senator MURKOWSKI. What are the training implications of contingency planning? Would the VA staff need different skills, perhaps different equipment, to handle combat casualties? For example, if about half of the VA beds are psychiatric, would those hospitals be ready to treat burn cases and other acute disabilities?

Dr. CUSTIS. Incidentally, the VA—I believe 30 percent of their total beds are dedicated to psychiatry, not 50.

Senator MURKOWSKI. Not 50. Thank you. The record stands corrected.

Dr. CUSTIS. The VA has an extremely large percentage of its physicians who have had military experience. Of the 11,000 physicians, some 85 percent have medical school faculty appointments. As a matter of fact, 45 percent of our physicians are part-time employees of the VA and part-time employees of the affiliated medical schools.

The point I am trying to make is that we are talking about a highly skilled cadre of physicians, people who teach such courses. Even so, I am sure that the VA as we plan for this thing would appropriately organize refresher courses in combat casualty care.

Senator MURKOWSKI. Under Executive Order 11490 the Veterans' Administration is charged to plan for emergency functions under all conditions in a national emergency including an attack on our Nation. Could you briefly outline what has been done to implement this order?

Dr. CUSTIS. There have been several drills and analyses of the response to those drills. I believe I am right in saying that the planning, however, to make such combined, cooperative effort effective is in its early stage.

Senator MURKOWSKI. So you feel that there has been an adequate adherence to the Executive order.

Dr. CUSTIS. Yes, sir. Specifically, in the room is our representative on the FEMA-directed planning committee, Mr. Dick Citron. You may wish to question him directly.

Senator MURKOWSKI. I would like to have your views on the situation of the eight Public Health Service hospitals that are supposed to be closed. You have already indicated the concern about dependents who would potentially come in under the sharing concept. I assume those dependents, though, are already being taken care of in the military hospitals and/or the CHAMPUS or the private sector or whatever. So it is questionable if there would be any more dependents actually being treated, but more would theoretically come to the Veterans' Administration hospitals because of convenience I suppose. So for that reason you would suspect that you would be required to give more care.

My question, though, is more or less in two parts. We are recognizing that the Public Health Service hospitals for the fishermen and the merchant seamen have been cut for budgetary reasons. Do those hospitals, in your opinion, have any value to be assimilated into the sharing system between the VA and the DOD?

Dr. Custis. Yes, sir. I think there is potential for both DOD and the VA to use at least some of those facilities.

Senator Murkowski. You feel they have a value and they are not outdated or totally inefficient, they do have some value. Do you feel that the VA would be interested in acquiring them from the General Services Administration?

Dr. Custis. The VA has a sizable problem in the immediate future and that is the aging veteran. Whereas now some 13 percent of our patients are over the age of 65, by 1990 one-third of all VA patients are going to be over the age of 65. Congress in its wisdom, giving the veteran an option to medicare has authorized any veteran over the age of 65 priority access to care within the system. We are lagging in our preparations to handle that impact.

I can, for example, think of one Public Health Service hospital that might well be exclusively devoted to extended and nursing home care.

Senator Murkowski. Do you feel that there would be a receptiveness on the part of the Veterans' Administration in cooperation with the DOD to temporarily assimilate these hospitals until there could be an adequate phaseout of the Government's responsibility for care to the seamen and fishermen. In other words, as it stands now, facilities are going to be closed and there is no provision, to my understanding, for utilization of hospitals in the private sector and there is a good deal of concern over what the Government's obligation is to these beneficiaries. My question to you is: Would you have a willingness to temporarily try and accommodate them, assuming that you could have these hospitals and whatever is needed as the proper foundation for care?

Dr. Custis. I would divide my answer, Mr. Chairman, into two parts. One, there are Public Health Service hospital beneficiaries that currently do have eligibility for care in both DOD and VA hospitals; namely, the retired uniformed services people and the Coast Guard.

In the case of the VA it is a very low priority, I think one of the lowest priorities. On the matter of the merchant marine I think it is a question of whether or not they retain or lose their entitlement for Federal care.

Then finally there is the question that I would refer to again—that demand for care is exceeding our resources. Accommodation of additional patients would have to be predicated on the receipt of more resources.

Senator Murkowski. Well, if the hospitals are terminated at the end of a given period of time, they are going to have patients in them. Somebody is going to have to take care of those patients that are hospitalized. But if those hospitals were made available, you would be willing to take a look at it.

Dr. Custis. You are talking about a transition period.

Senator **Murkowski**. Yes.

Dr. **Custis**. Yes, sir.

Senator **Murkowski**. I think that concludes the questioning, Dr. Custis. We certainly appreciate the presentation and we appreciate the presence of your associates, Dr. Carl Hughes and Mr. Ralph Ibson, Deputy Assistant to the General Counsel. The balance of your remarks will be included in the record. We thank you, gentlemen.

We will proceed with testimony from the Federal Emergency Management Agency. Mr. John McConnell, Acting Associate Director of Plans and Preparedness, will be accompanied by Mr. George Jett, General Counsel, and Mr. Fredrick Haase. We welcome you to the Committee on Veterans' Affairs and ask your forbearance in view of the time elements and constraints we have. If you would keep your presentation, hopefully, to 5 minutes or summarize, the Chair would be very grateful. With that, Mr. McConnell, we welcome your submission of testimony.

TESTIMONY OF JOHN W. McCONNELL, ACTING ASSOCIATE DIRECTOR, PLANS AND PREPAREDNESS, FEDERAL EMERGENCY MANAGEMENT AGENCY, ACCOMPANIED BY GEORGE JETT, GENERAL COUNSEL, AND FREDRICK HAASE

Mr. **McConnell**. Thank you, Mr. Chairman. I am the Acting Associate Director for Plans and Preparedness for the Federal Emergency Management Agency. During the time our current Director was pending confirmation by the Senate, I was Acting Director of the Agency.

The Federal Emergency Management Agency welcomes the opportunity you have extended to participate in this important hearing on proposed legislation to facilitate the sharing of medical resources between the Veterans' Administration and the Department of Defense and to establish the Veterans' Administration as the primary backup to the Defense Department for medical contingencies associated with war or national emergencies.

FEMA's interest in this legislation stems from its assignment of primary responsibility for coordination and oversight of civil emergency preparedness plans and programs, pursuant to section 2, Executive Order 12148, Federal emergency management; and sections 102, 103, 3001, and 3008 of Executive Order 11490, as amended.

In time of national emergency, a crucial need is for central control, coordination, and management of the planning for and the actual use of the Nation's essential resources likely to be required; for example, hospital beds.

FEMA was created to perform this important function for the President. The Department of Health and Human Services has the assigned responsibility, under FEMA's guidance, to develop plans and programs for mobilization of the Nation's health resources, including hospital beds.

The concept embodied in S. 266—for example, the sharing of resources for substantial savings, without jeopardizing effectiveness and readiness for emergencies—we strongly endorse.

However, since this legislation deals with peacetime sharing, we defer to the Department of Defense and the Veterans' Administration on the specifics of this bill.

Regarding H.R. 3502, which we understand your committee is considering in part at this time, we offer these comments:

We believe the VA may have the potential capacity to expand beds under extreme emergency conditions in numbers that would more than likely meet all DOD needs. This has been shown in our practice exercises.

In August 1980, the Administrator of Veterans' Affairs wrote the Director of FEMA to inform him that the VA was in the process of studying and planning its emergency capabilities regarding bed capacity. The Director of FEMA expressed the hope that the study effort would validate the fourfold expansion factor used in the REX-80-ALPHA exercise for calculating VA bed-augmentation potential.

The study results should be useful in considering this type of legislation. Additionally, the administration will be reviewing this issue in context with other broad national security implications during the next few months. Consequently, we are unable to take a formal position at this time. However, we do offer the following comments:

In section 2(g)(4), page 10, we consider the proposal to circumvent the established executive branch procedures for budget and program review as an unwarranted incursion into the prerogatives of the Executive and strongly object to this provision.

In section 2(g)(5), we question the value of the report called for in this section, as in a national emergency the fluidity of the situation would make it difficult to assess accurately ultimate needs within so short a period after issuance of a Presidential order.

In section 2(g)(6), we believe careful consideration should be given to the proposal which would relieve VA personnel from any military service obligation, thus creating a privileged group. The health manpower supply situation will be such that no problems should be experienced in obtaining VA replacements for those called to military service through the present standby random selection method.

Present policy provides no deferments are granted members of the Ready Reserve because of their civilian employment. We see no reason for a special rule for this limited group of personnel.

Thank you, Mr. Chairman. I will be glad to answer any questions.

Senator MURKOWSKI. I commend you, Mr. McConnell, you are right on 5 minutes.

[The responses of the Federal Emergency Management Agency to written questions submitted by Hon. Alan K. Simpson, chairman of the Senate Committee on Veterans' Affairs and Hon. Alan Cranston, ranking minority member, follow:]

RESPONSE OF THE FEDERAL EMERGENCY MANAGEMENT AGENCY TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN K. SIMPSON, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

A. Since FEMA is responsible for civil emergency preparedness, why did you defer in your testimony to DOD and VA in regard to the preparedness implications of peacetime sharing under S.266?

B. Do you believe that peacetime sharing as proposed in S.266 would contribute to a state of readiness for response to a state of war or national emergency?

Answer 1.

A. Since S.266 makes no mention of emergencies or preparedness, we interpreted it to be applicable only to non-emergency or peacetime situations and therefore, we deferred to the DOD and VA.

B. Peacetime sharing could impinge upon emergency preparedness planning (e.g., the peacetime pre-emption of hospital resources for emergency use). Normally, however, peacetime sharing of laundry and similar support services and professional and diagnostic services such as CAT scanners and dialysis facilities would not substantially detract from national readiness capabilities.

Question 2.

In the event of a civil emergency (as defined in E.O. 12148, sec. 2), who is in charge of emergency management of Federal resources across agencies? Specifically, in case of an attack on the United States, who could order the VA hospitals to accept battlefield casualties and who could order the DOD hospitals to accept civilians?

Answer 2.

In the event of a civil emergency (as defined in E.O. 12148, sec. 2), the President exercises the ultimate authority and responsibility for the emergency management of Federal resources. The Director, FEMA, serving as the agent and principal advisor of the President on civil emergency preparedness and the total national preparedness program, could order the allocation of available resources (e.g., hospital beds) for specific priority uses, in keeping with Presidential policy. The process leading to such a decision would involve consultation with all interested parties and consideration of relative urgencies for the use of resources.

Question 3.

You cited the responsibility of the Department of Health and Human Services (HHS) to develop plans and programs for mobilization of the Nation's health resources including hospital beds. In what situations would this responsibility be exercised, and to what extent does it include VA and DOD hospital beds?

Answer 3.

Section 102(c), E.O. 11490 states that the heads of departments and agencies shall:

"(1) prepare national emergency plans, develop preparedness programs, and attain an appropriate state of readiness with respect to the functions assigned to them in this order for all conditions of national emergency; (2) give appropriate consideration to emergency preparedness factors in the conduct of the regular functions of their agencies, particularly those functions considered essential in time of emergency; and (3) be prepared to implement, in the event of an emergency, all appropriate plans developed under this order."

Section 3008(3), E.O. 11490 states:

"Emergency plans, programs, and an appropriate state of readiness, including organizational readiness, shall be developed as an integral part of the continuing activities of each department or agency on the basis that that department or agency will have responsibility for carrying out such plans and programs during an emergency. The head of each department or agency shall be prepared to implement all appropriate plans developed under this order. Modifications and temporary organizational changes based on emergency conditions shall be in accordance with policy determinations by the President."

Section 3011, E.O, 11490 states:

"This order does not confer authority to put into effect any emergency plan, procedure, policy, program, or course of action prepared or developed pursuant to this order. Plans so developed may be effectuated only in the event that authority for such effectuation is provided by a law enacted by

Answer 3 (continued).

the Congress or by an order or directive issued by the President pursuant to statutes or the Constitution of the United States."

Thus, DDHS, which in Section 1101 of Part 11, E.O. 11490, is assigned responsibility for preparing national emergency plans and developing preparedness programs covering health services, civilian health manpower, health resources, welfare services,...etc., would implement these mobilization plans only when directed to do so by the President or his agent, the Director, FEMA. DHHS, as the health resources agency, would develop an overall national health resources assessment, including VA and DOD health resources assets. In the event of a national emergency, DHHS would carry out a continuing assessment and coordinate the use of the Nation's health resources. Both VA and DOD would manage their own facilities and coordinate with DHHS in making use of these resources in a national emergency.

Question 4.

You make reference to Executive Order 11490, which was issued October 28, 1969, and amended on June 11, 1976. It calls for numerous "national emergency plans" and related guidance materials. Where are these plans located, and how often are they updated to assure that they are responsive to changing conditions or to additional knowledge about disaster effects and mitigation?

Answer 4.

The national emergency plans are maintained in FEMA headquarters, FEMA Regional offices, and emergency facilities. Some of the documents are maintained in the National Security Council and the White House. Those elements of plans to be implemented by other government agencies are available in their headquarters and emergency operating locations. Guidance and plans are reviewed and revised any time National policy is changed.

Question 5.

In response to a question, you indicated that FEMA's functional responsibilities are an outgrowth of "plans." What do you mean by "functional responsibilities" and do you feel that "plans" are an adequate basis for authority to execute these responsibilities?

Answer 5.

By function and responsibility, we mean the actions and measures for which FEMA is responsible, e.g., coordination of civil emergency planning, or establishment of policy. Plans, in and of themselves are not adequate authority for their own execution and E.O. 11490 specifically provides that plans may be effectual only in the event that authority for such effectuation is provided by a law enacted by the Congress or by an order or direction issued by the President pursuant to statute or the Constitution. .

Question 6.

You indicated that FEMA's functional responsibilities are "subject to the assignment of a specific task by the President." Who advises the President as to which specific tasks should be assigned, and what are the roles of the Cabinet and OMB in such assignments?

Answer 6.

FEMA advises the President as to who should perform specific tasks, and FEMA defines the roles of the agencies.

Question 7.

"Central control" is identified in your prepared testimony as a function FEMA performs for the President. Yet, in response to a question, you stated, "All of our activity short of a war-declared emergency is in the area of planning and coordinating." Please clarify the distinction you are making between the situations in which you control and those in which you coordinate.

Answer 7.

In a declared national emergency, FEMA would serve as the President's principal arm and advisor on the central coordination and management / control of the Nation's resources. Preparatory to that role, FEMA coordinates total emergency planning and preparedness at the Federal, State, and local government level and in the private sector. In both the pre-emergency and emergency phases, FEMA controls the program of priorities and allocations of critical materials for defense production, national security, health, and welfare under authority of the Defense Production Act of 1950, as amended and the National Security Act of 1947. During "disasters" and "emergencies", as defined in the Disaster Relief Act of 1974, FEMA manages/controls the Federal response through its designated Federal Coordinating Officer (FCO), who controls Federal actions through the setting of priorities and issuance of tasking orders to Federal agencies. In the event of a major war, FEMA would take on a temporary responsibility for controlling production and distribution of products essential to military and civilian needs and elements of the economy necessary to maintain economic stability.

Question 8.

In regard to your responsibility for "oversight of civil emergency preparedness plans and programs," what are your findings in regard to the adequacy of the VA's plans for response to the medical needs which might be generated by civil emergencies.

Answer 8.

See answer to question 10.

Question 9.

In relation to the possibility of a Southern California earthquake, you refer to planning that "has been undertaken", "that is still ongoing", and that "is in various stages being improved". Is there, or will there be a product of this planning, or is the emphasis on the process? How have you coordinated the efforts of the VA and DOD, and what is their planned response for sharing resources in the event of a massive earthquake in Southern California?

Answer 9.

A major cooperative effort is now underway to improve earthquake preparedness in Southern California for earthquake occurrences or their prediction. The effort is jointly funded by the State and Federal governments and includes local government, and business and public institutions as major participants. This is an innovative effort to develop compatible and complimentary preparedness plans by all elements of government and the private sector. The initial phase concentrated on designing a process for cooperative planning. The process is now being implemented and will begin delivering products this fall. The area potentially impacted by a Southern California earthquake is very large, entailing many jurisdictions and a wide variety of social and business institutions. Thus, completion of the planning effort is expected to take about three years. The federal component is managed by our regional office in San Francisco. They are being assisted by a regional committee of Federal agencies, including participation from Department of Defense and the Veterans Administration, as well as 17 other Federal agencies. Specific annexes to the draft Federal plan have been prepared for each agency which detail their overall and specific responsibilities, including the sharing of resources. An interim Federal plan will be in place by October 1981, with refinement and integration with other governmental elements to follow over the next two years.

Question 10.

You stated your belief that "the VA has the potential capacity to expand beds under extreme emergency conditions in numbers which would more than likely meet all DOD needs." However, a recent GAO report (DOD Needs Better Assessment of Military Hospitals' Capabilities to Care for Wartime Casualties, May 19, 1981) states that "Current DOD war planning scenarios result in casualty estimates so large that non-Federal civilian medical resources would be needed even if both DOD and VA capabilities were fully used to treat battlefield casualties." How do you reconcile these different points of view?

Answer 10.

The basis for our belief was the recent civil readiness exercise in which DHHS assigned VA responsibility for providing 120,000 beds, which was the number estimated by DOD. However, the VA does not believe it can meet this responsibility and needs to reevaluate its current capability to expand bed capacities for such various contingencies as: an overseas war, an attack on the United States; or a localized major natural or technological disaster.

RESPONSE OF THE FEDERAL EMERGENCY MANAGEMENT AGENCY TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

A. On page 1 of your testimony, you note that FEMA has primary responsibility for "coordination and oversight of civil emergency preparedness". Does this definition of responsibility extend to planning and coordination for the care of military casualties of an overseas conflict?

B. (if yes) What plans has FEMA developed to provide health care to such casualties?

Answer 1.

A. Primary responsibility for planning for the care of military casualties of an overseas conflict lies with the Department of Defense (DOD). Emergency preparedness functions are to be coordinated by the head of the department or agency having primary responsibility with all other departments and agencies having supporting functions related thereto. Thus, DOD would coordinate its casualty treatment plans and requirements, insofar as they relate to non-military resources, with the appropriate federal civil resource agency (e.g., DHHS--health resources; DOT--transportation; DOC--production, etc.). FEMA should be kept informed by DOD and the resource agencies and coordinate the performance of the involved functions with the total national preparedness program. The pattern for the foregoing is set out in the guidance promulgated in E.O. 11490, Assigning Emergency Preparedness Functions to Federal Departments and Agencies.

B. Not applicable. See above.

Question 2.

On page 1 of your testimony, you note the need for "central control, coordination, and management of the planning for and the actual use of the Nation's essential resources in time of "national emergency."

A. Does the term "national emergency" as used in your testimony have a specified, legal meaning and, if so, what constitutes a "national emergency" sufficient to trigger FEMA's role in this regard?

B. Who determines that the Nation is in such a state of "national emergency?"

C. Could an overseas armed conflict involving U.S. forces constitute such a "national emergency"?

Answer 2.

The term "national emergency" was used in a broad sense. It means some set of circumstances which request the use of authorities not normally available to an agency. We use it in a Presidential sense. Only the President may proclaim a "national emergency," and he must follow the National Emergencies Act procedures when he does so.

Question 3.

In the event of such a "national emergency", what would be the VA's role as a health-care provider and what plans exist at present describing this role?

Answer 3.

The VA role is described in Part 29 of E.O. 11490 as follows:

see excerpt - Attachment A

In addition, Federal Emergency Plan D (Secret) provides for the VA to participate in civil emergency health service planning and operations at the Federal national and regional levels in support of the DHHS responsibility to provide health services to the non-military population of the Nation through established channels. A memorandum of agreement between the VA and DHHS covers the details.

[Attachment A]

Part 29 - Veterans Administration

Section 2901. Functions.

o Develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veteran's Administration under all conditions of national emergency including attack upon the United States.

(1) the emergency conduct of inpatient and outpatient care and treatment in Veterans Administration medical facilities and participation with the Departments of Defense and Health and Human Services as provided for in interagency agreements.

(2) the emergency conduct of compensation, pension, rehabilitation, education, and insurance payments consistent with overall Federal plans for the continuation of Federal benefit payments.

(3) the emergency performance of insurance and loan guaranty functions in accordance with indirect stabilization policies and controls designed to deal with various emergency conditions.

[Attachment B]

MEMORANDUM OF UNDERSTANDING BETWEEN THE VETERANS ADMINISTRATION AND THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, REGARDING PARTICIPATION IN EMERGENCY HEALTH SERVICE PLANNING AND OPERATIONS

In recognition of the substantial emergency health responsibilities and resources of the Veterans Administration (VA), and in accordance with Executive Order No. 11490, and the National Plan for Emergency Preparedness, this Memorandum of Understanding has been agreed to by the VA, Department of Medicine and Surgery (DM&S), and the Department of Health, Education, and Welfare (DHEW), Public Health Service (PHS), and is published for the guidance and information of all concerned.

I. PURPOSE. The purpose of this memorandum is:

A. To ensure the maximum emergency utilization of VA health resources following an attack upon the United States.

B. To facilitate the early development of joint emergency health operating plans.

C. To describe the medical and health program planning areas in which the VA and DHEW will assist each other.

D. To describe procedures for the maintenance of interagency working relationships in the health and medical fields.

II. AUTHORITY. In accordance with Executive Order No. 11490, "The Administrator of Veterans Affairs shall develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veterans Administration under all conditions of national emergency, including attack upon the United States. These include: (1) The emergency conduct of inpatient and outpatient care and treatment in Veterans Administration medical facilities and participation with the Departments of Defense and Health, Education, and Welfare as provided for in interagency agreements.

III. EMERGENCY OPERATIONS. In the initiation and conduct of emergency operations, the following general policies will prevail:

A. Headquarters. The VA Central Office staff shall have a substantial role in the Federal Emergency Health Service (EHS). A VA DM&S official shall serve as Associate Chief, EHS. Certain predesignated VA employees will relocate at the DHEW Relocation Site as part of the EHS Cadre; others will report there for duty at D plus 14 or later. The specific emergency responsibility of each assignee will be determined in advance by mutual agreement between PHS and DM&S. Relocation assignments to the DHEW Relocation Site shall not conflict with or compromise other VA emergency preparedness functions assigned by executive order or other appropriate authority.

B. Regional Offices. Selected VA field personnel shall have prearranged emergency relocation assignments to the appropriate EHS Regional Office. A predesignated VA field official shall be Associate Chief, Regional EHS, at each of the ten DHEW Regional Offices.

C. Medical Care Facilities. Following an attack upon the United States:

1. VA will continue to maintain jurisdiction over its medical facilities.

2. VA station directors shall retain full control of their facilities, material resources, and personnel.

3. In the immediate postattack period, VA facilities shall participate fully to help meet local emergency medical needs.

4. Emergency operations shall be conducted in accordance with prearranged plans and agreements with State and local civil defense and health authorities, the DHEW Regional EHS Chief, the VA official designated as Associate Chief, Regional EHS, and--where feasible--the County Medical Society.

5. Specific field facilities shall revert to their primary statutory mission at such time as determined by higher authority. Such determinations shall be made after consultation with State and local civil defense and emergency health authorities.

IV. EMERGENCY PLANNING. In the joint planning and preparation for emergency health operations, the DM&S and the PHS shall be guided by the following policies:

A. Interagency Working Relationships and Liaison. Written communications between DM&S and PHS headquarters shall be channeled through or endorsed by the Division of Emergency Health Services (DEHS), Health Services and Mental Health Administration, the unit responsible for DHEW emergency health activities. Communications originating at PHS headquarters and directed to DM&S will be sent to the Chief Medical Director with copies for the

VA Defense Coordinator. Staff units and officials of DM&S and PHS shall meet or confer informally to discuss matters of joint concern.

At the regional and field level, joint planning shall be conducted by contact between VA-designated Associate Chiefs, Regional EHS, and the DEHS Regional Program Directors. Formal arrangements shall be approved by the DHEW Regional Health Directors and the Associate Chiefs, REHS. Regional policy precedent matters shall be referred to headquarters for interagency action and resolution.

B. Joint Issuance. Each agency shall routinely provide to the other all pertinent emergency issuances. Proposed issuances directly involving the other agency shall be submitted to that agency for review and clearance prior to publication.

C. Essential Records and References. Designated VA relocatees to EHS shall select record and reference materials essential to the conduct of their assigned emergency responsibilities. These materials shall be filed at the DHEW Relocation Site in conformance with DHEW policy and procedures.

D. Security. All designated DM&S headquarters relocatees, both principal and alternate, shall have security clearance. D-minus cadre relocatees shall have clearance based upon full field investigation.

E. Exercises and Tests. Designated VA relocates shall participate in EHS headquarters and regional exercises and tests.

FOR THE VETERANS ADMINISTRATION	FOR THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
/s/ Chief, Medical Director	/s/ Assistant Secretary for Health and Scientific Affairs
/s/ Defense Coordinator	/s/ Defense Coordinator

March 14, 1972
Date

Question 4.

On page 2 of your testimony, you note your belief that "the VA has the potential capacity to expand beds under extreme emergency conditions in numbers which would more than likely meet all DOD needs" and that this fact has been shown in exercises.

A. Please describe discussions between your agency and DOD regarding this assessment.

B. Please provide more information describing those exercises and state when they were held, how many beds the VA was shown to have the ability to provide, and how the VA was able to accomplish that.

Answer 4.

A. An ad hoc Health, Medical, and Human Services Committee with representatives from FEMA, VA, DOD, and DHHS began monthly meetings, commencing in August 1980, to address common interest issues including those arising as an experience in the REX-80 Alpha exercise. The FEMA Chairman discussed the need for joint civil/military emergency planning requirements and planning factors and furnished the attached outline (Attachment C) as suggestive of the type of data which needed to be developed to provide a sound basis for planning activity. Agencies were asked to come into subsequent meetings with their own statements of information needs. The REX-80 Alpha exercise play developed the fact that PHS and VA, who played jointly in addressing some exercise problems, were using a factor of four for the bed expansion capability of VA hospitals and a factor of two for expanding the bed capacity in emergencies of civil hospitals. FEMA was unable to ascertain the rationale for using these factors from the PHS and VA. This point was made in the August 20, 1980, meeting by the FEMA Chairman as the principal reason for this initiative. VA and DOD representatives were present and, subsequently, they have reported that they have been engaged in joint studies and planning, presumably to develop a factual basis for basing operational procedures. FEMA anticipates the outcome of this joint effort may clarify the true bed capacity in emergency of both the military and VA hospital systems. It should be noted that DHHS plans to close or transfer to local community control of the PHS hospitals.

B. REX-80 Alpha was a civil readiness exercise conducted by the Federal Emergency Management Agency and associate Federal departments

Answer 4B (continued).

and agencies during the period March 24-28, 1980, to identify problem areas where corrective action might be needed. The VA was assigned responsibility for providing 120,000 beds according to DHHS's exercise report to FEMA. It was FEMA's understanding that VA could expand its normal bed capacity fourfold in emergency. However, the VA has stated that it must conduct studies to reevaluate its current capability to expand its bed capacities for various contingencies, such as: an overseas war, an attack on the United States, or a localized major or technological disaster. It should be remembered that REX-80 ALPHA was an exercise and involved an attack on the CONUS with damage to some VA capacity.

[Attachment C]

Joint
Civil/Military
Emergency Planning
Requirements
and
Planning Factors

- Projected use of health manpower by:
  - department/agency
  - skill category/specialty
  - time phase
  - source of procurement
  - numbers

- Usage factors for essential survival items by:
  - major category
  - selected products/end items
  - time phase
  - quantities
  - dosage quantity

- Hospitalization planning factors
  - rated bed capacity by type facility
  - expansion factors for emergency

Question 5.

Also on page 2, you state:

> In August 1980, the Administrator of Veterans' Affairs wrote the Director, FEMA, to inform the latter that the VA was in the process of studying and planning its emergency capabilities regarding bed capacity. The Director, FEMA, expressed hope that the study effort would validate the four-fold expansion factor used in REX-80 ALPHA for calculating VA bed augmentation potential.

A. Please provide copies of this exchange of correspondence.

B. Please explain the meaning and significance of the following terms: "four-fold expansion factor '; "REX-80 ALPHA"; and "bed augmentation potential".

Answer 5.

A. Copies of the correspondence referred to are attached as follows:

- o Letter, August 21, 1980, Max Cleland, Administrator of Veterans' Affairs to John W. Macy, Jr., Director, FEMA.
- o Letter, September 24, 1980, John W. Macy, Jr., Director, FEMA, to Max Cleland, Administrator of Veterans' Affairs.

B. (1) four-fold expansion factor - the capability to expand normal bed capacity by a factor of four or multiplier of four in an emergency, thus accommodating an inpatient population four times the size normally supportable.

(2) REX-80 Alpha - a civil readiness exercise sponsored by FEMA and conducted concurrently and in parallel with the Joint Chiefs of Staff Exercise Prize Gauntlet-80 during March 1980.

(3) bed augmentation potential - the latent capability to increase in emergency the number of inpatients a hospital can accommodate for treatment. This implies manpower, supplies, equipment, space and supporting services are readily available for emergency use as required.

[Attachment D]

of Veterans Affairs

Veterans
Administration

AUGUST 21 1980

Honorable John W. Macy, Jr.
Director, Federal Emergency
Management Agency
Washington, DC 20472

Dear Mr. Macy:

I am pleased to send you my comments, as stated to the Chairman, Senate Committee on Governmental Affairs, and to the Chairman, House Committee on Government Operations, on the Comptroller General's June 26, 1980 report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System," HRD-80-76.

The Veterans Administration's (VA) position remains unchanged from that taken in our May 13, 1980 response to the draft report, printed on pages 47-49 of the final report. However, we would like to re-emphasize that implementation of the recommendations directed specifically to the VA is contingent upon appropriate legislation being passed. It should also be noted that providing bed estimates to the Department of Defense (DoD) concerning our potential capabilities, plus specific emergency plans, will require the VA to carry out extensive studies and planning prior to data being available. Efforts are already proceeding in this direction. The VA has begun an interface with the Federal Emergency Management Agency to deal with the concerns outlined in your Agency's response to the draft report.

You may be assured the VA will cooperate in any way it can to plan the Military-VA-Civilian contingency hospital system.

Sincerely,

Max Cleland

MAX CLELAND
Administrator

[Attachment E]

COPY

Sep 24, 1980

Honorable Max Cleland
Administrator of Veterans Affairs
Veterans Administration
Washington, D. C. 20420

Dear Max:

Your comments on GAO report HRD-80-76, which you provided in your August 21, 1980 letter to me are helpful and reassuring.

Regarding your reference to the need for appropriate legislation, I have enclosed a copy of our staff comments to OMB on the VA draft bill "to amend title 38, U.S. Code to authorize the Veterans' Administration to assist the Department of Defense in the care of military personnel injured in armed conflict and for other purposes." We do not disagree that legislation may eventually be needed, but we believe more intensive staff discussions and coordination between DOD, VA, DHHS, SSS, and others are indicated to confirm the need and the form of legislation required.

I am pleased to learn that the VA is in the process of studying and planning its emergency capabilities regarding bed capacity. I hope this effort will validate the fourfold expansion factor used in REX-80 Alpha for calculating VA bed augmentation potential.

Fred Haase, FEMA's Health Resources Manager, has inaugurated a series of monthly interagency coordinating meetings in which your staff has actively participated. The Military-VA Civilian Contingency Hospital system will be a regular agenda item for some time and I expect these meetings to:

- o improve interagency coordination,
- o facilitate information exchange,
- o strengthen and integrate the Federal emergency health, medical and welfare planning and response activities, and
- o provide a conduit for guidance and policy dissemination.

I appreciate your assurance of continued VA cooperation and I take this opportunity to thank you and your staff for the fine support we have enjoyed in the past.

Sincerely yours,

John W. Macy, Jr.
Director

Enclosure

Senator MURKOWSKI. What are the differences in FEMA's authority in wartime and peacetime national emergency situations, and to what extent do you have management responsibility in addition to your role as a coordinator?

Mr. McCONNELL. Mr. Chairman, the authorities are very broad but specific with regard to planning and coordinating responsibilities. The functional responsibilities are somewhat limited and are an outgrowth of those plans that would primarily be subject to the assignment of a specific task by the President as——

Senator MURKOWSKI. When the President declares a national emergency, is that what triggers your activity and your responsibility under a wartime scenario?

Mr. McCONNELL. To carry out action, yes, sir.

Senator MURKOWSKI. Are your charges or responsibilities pretty much the same in either wartime or peacetime?

Mr. McCONNELL. Sir, in peacetime an emergency declared by the President under the Disaster Relief Act of 1974 provides specific authorities to deal with an emergency situation under those conditions. All of our activity short of a war-declared emergency is in the area of planning and coordinating. I hope that is clear.

Senator MURKOWSKI. Well, maybe we will get involved a little more here. Much of your role appears to be directed toward facilitating Federal aid to States and communities in the event of localized disasters. Is that correct?

Mr. McCONNELL. That is true both in preparing for disasters and assisting them upon the declaration of a disaster by the President under a specific set of circumstances.

Senator MURKOWSKI. To what extent is FEMA prepared to manage the coordination of Federal agencies—specifically, VA and DOD—in the case of national or regional disasters?

Mr. McCONNELL. You are speaking of peacetime disasters, Mr. Chairman?

Senator MURKOWSKI. That is correct.

Mr. McCONNELL. That is a specific charge that we have and, although I heard the representative of the Defense Department say that he could not identify a scenario that would call for unusual use of military resources such as hospitals in a natural disaster situation, we can point to the planning that has been undertaken and is still ongoing in southern California against a massive earthquake. In that case there certainly would be a total use of Federal resources available.

Senator MURKOWSKI. So you have a plan ready to go in case the crystal ball gazers come up with a magic date. Is that right?

Mr. McCONNELL. Our plan is in various stages of being improved.

Senator MURKOWSKI. And it involves the VA and the DOD and there is no question that they would be responsive to your directive which would implement their cooperation, so to speak.

Mr. McCONNELL. Absolutely, sir.

Senator MURKOWSKI. And they understand that they would adhere to your dictates.

Mr. McCONNELL. In the case of a Presidentially declared disaster, that is correct.

Senator MURKOWSKI. Did you ever hear of an outfit under the Environment and Public Works Committee, the Regional and Community Development Subcommittee which has disaster relief within its jurisdiction?

Mr. McConnell. No, sir, I don't believe I have.

Senator Murkowski. I happen to be a subcommittee chairman of that. I don't understand it too well, either. But it seems to have a similar responsibility. It says here: "We cover national disasters." However, the last one that they got involved in was Cuban relief. You can draw your own conclusions as to whether that should be included under national disaster. But I intend to hold hearings to find out just what this subcommittee does. [Laughter.]

And maybe we can do away with it. I don't know. That was just a little sidelight I thought I would tell you.

Mr. McConnell. Mr. Chairman, I would defer to Mr. Jett for the particulars of the situation. But that was an unusual type natural disaster. It was in fact declared by the President as a disaster and a FEMA Federal coordinating officer was put in charge and managed the situation in Florida, and FEMA arranged with the Defense Department and other agencies for disposition of it.

Senator Murkowski. Do you see that as a reasonable charge, that type of activity to be included under the Federal Emergency Management Agency?

Mr. McConnell. No, sir. We thought that was most unusual. We have worked with a Cabinet group to attempt to lay plans for other agencies more appropriately assigned responsibilities for the influx of refugees to handle situations like that.

Senator Murkowski. I have been advised that "national emergency" doesn't seem to be defined in the Executive order and as a consequence they evidently have used this disaster relief as a kind of convenient catchall.

Mr. McConnell. Do you know what the budget is?

Senator Murkowski. There is a budget for it I am told. But it is pretty hard, as you know, to predict what it is going to cost to become involved in a national disaster.

But I would appreciate very much if your associates would perhaps be willing to participate in this hearing to see if this other thing is needed. Would you be willing to do that?

Mr. McConnell. We would be glad to.

Senator Murkowski. Thank you. I want to take this opportunity, Mr. McConnell, to thank you for your presentation and also your associates, Mr. George Jett and Mr. Fredrick Haase. Thank you, gentlemen.

I would call the representatives up collectively from the Veterans of Foreign Wars, Mr. Donald Schwab, director, National Legislative Service; the American Legion, Mr. E. Philip Riggin, deputy director, National Legislative Commission, who will be accompanied by, I believe, Mr. Robert E. Lyngh, director, National Veterans Affairs and Rehabilitation Commission. From AMVETS, Gabriel Brinsky, national service and legislative director; and, representing the Disabled American Veterans, John F. Heilman, national legislative director.

Before we proceed, I welcome you to the Committee on Veterans' Affairs. I ask your forbearance in limiting your comments to 5 minutes or less and summarizing your statements. And, with that why don't we introduce ourselves, starting with Mr. Schwab, who happens to be first.

Don, welcome to the meeting—you're on the furthest left, right? And, Mr. Riggin, Mr. Lyngh. Mr. Brinsky?

Mr. **Brinsky**. Here.

Senator **Murkowski**. Over and out. And, Mr. Heilman?

Mr. **Heilman**. Yes.

Senator **Murkowski**. All right, Mr. Schwab, proceed.

TESTIMONY OF DONALD SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. **Schwab**. Thank you, Mr. Chairman. It is my privilege to represent the more than 1.9 million men and women of the Veterans of Foreign Wars as the legislative director. And, as you requested, I'll summarize my statement with the understanding that it will be published in full in the record.

Senator **Murkowski**. It will.

Mr. **Schwab**. The Veterans of Foreign Wars supports wholeheartedly the further sharing of medical resources and facilities between the Veterans' Administration and the Department of Defense. And, by all means that the Veterans' Administration be designated the No. 1 backup to the Department of Defense to care for battle casualties whether or not it is anticipated that they will be returned to active duty.

We were quite chagrined when DOD, on the basis of the Maximus Report, went out to civilian communities to arrange for beds for wartime casualties before going to the VA. I believe that situation has been rectified at this point and I'm happy to say that we support this wholly. We support any legislation that this committee deems proper for more integration of sharing between VA and DOD.

In my statement, I address Public Health Service hospitals because I don't think that if you're talking about Federal health facilities you can ignore the Public Health Service hospitals while they exist. The VFW supports the continuance of the Public Health Service hospital system and would oppose its demise as proposed by the administration.

However, we would object to introducing into the VA and DOD overburdened hospital systems—the broad universe of civilians now serviced by the Public Health Service. The Public Health Service does care for members of the U.S. Coast Guard, their dependents and retirees. And, on a reciprocal basis, the active duty personnel and retirees of the Armed Forces.

We approve of this, we think it's a satisfactory arrangement and we would not like to see that disturbed. And, I'll be happy to respond to any questions you may have in later hours.

Senator **Murkowski**. Thank you, Mr. Schwab. In view of the very real likelihood that Public Health Service hospitals will be discontinued, do you feel that it would be appropriate as part of the recognition of the increasing need for hospital facilities for veterans because of the natural aging process and the likelihood that you're going to need more beds, that those hospitals be assimilated by the Veterans' Administration, or at least they review those facilities to determine whether or not they might be utilized within the system?

Mr. **Schwab**. Well, it's a possibility, yes. Our field representatives, of course, have not surveyed Public Health Service hospitals, which I understand are aging as a group, but there is a growing, a rapidly growing need for extended care for veterans, particularly nursing care. And, the VA has unfortunately dragged its feet in this area. They are presently operating only 8,390 nursing care beds and they are authorized by public law to operate not less than 12,000 nursing care beds at the present time.

So, in this area, I think, further utilization could possibly be made at some of those Public Health Service facilities.

Senator **Murkowski**. Thank you, Mr. Schwab.

[The prepared statement of Donald H. Schwab follows:]

VFW
VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL LEGISLATIVE SERVICE
Office of Director

PREPARED

STATEMENT OF

DONALD H. SCHWAB, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

THE SHARING OF MEDICAL FACILITIES OF THE
VETERANS ADMINISTRATION, THE DEPARTMENT OF DEFENSE
AND THE PUBLIC HEALTH SERVICE

WASHINGTON, D. C. JUNE 17, 1981

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 1.9 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

Mr. Chairman, at the request of the Honorable Robin Beard to review the Department of Defense plan to use non-military hospitals to treat battlefield casualties in the event of war or conflict, in June of last year the Comptroller General submitted a report to Congress entitled "The Congress

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Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System." As was brought out in this report, and against the recommendation of the GAO, DOD is implementing a civilian-military contingency hospital system wherein civilian hospitals will be linked by formal agreement to the DOD hospital system. DOD is now exploring possibilities of using VA facilities which, in our opinion, should have been undertaken before any agreements were entered into with civilian hospitals.

As background, DOD's normal hospital bed capacity at the time was reported at approximately 35,000. However, they neither have the beds, staff nor equipment needed to make the space usable for 35,000 beds. According to the GAO report, fewer than 20,000 beds were actually set up, staffed and equiped and the average daily census was less than 16,000. Predicated upon a 1979 report by Maximus, Inc., a private contractor, DOD would obtain access to approximately 40,000 beds in civilian facilities for wartime use. The Veterans Administration is currently operating less than 83,000 beds with the daily census of a little over 67,000 with an Administration projected reduction in fiscal year 1982 to 78,900 operating beds and a daily census reduced to 64,000. However, the House recently passed H.R. 3499, the "Veterans Health-Care Act of 1981" which, among other provisions, would require the VA to establish not more than 125,000 or less than 100,000 hospital and nursing care beds in VA facilities and operate and maintain not less than 82,500 hospital beds and not less than 9,000 nursing care beds.

The V.F.W. believes the VA should, without question, be the number one backup for the Department of Defense medical care system. This, first and foremost, because the VA has had the greatest expertise over the years in treating combat incurred disabilities.

As pointed out in the GAO report, legislative action is required to permit the VA to care for battle casualties expected to be returned to active duty. GAO recommends such legislative action and, in addition, placing the treatment of battlefield casualties above veterans with non-service-connected disabilities and non-emergent conditions.

The need for such legislation is dramatically illustrated by the following extract from Senate report No. 96-978 prepared by the Senate Committee on Governmental Affairs following hearings with respect to S. 2958, the proposed Federal Interagency Medical Resources Sharing and Coordination Act of 1980.

"The second panel consisted of two federal hospital administrators. A Veterans Administration hospital administrator and Navy Hospital Commander, both from San Diego, described their attempts to implement several sharing arrangements. For instance, the Veterans Administration offered use of its "Argon Laser" devise, used to treat eye disorders, to the Navy at no charge. The unit was being used primarily for research at the Veterans Hospital, and was unused several mornings each week. The Navy had no laser unit of their own at the time. This factor forced the Navy to buy treatments in the private sector where long delays in obtaining treatment on a private hospital's device was causing harm to some Navy patients. Thus, the Navy Commander agreed to the VA's proposal which would save the Navy and the taxpayer money. Also, having time set aside at the VA would assure prompt treatment.

"The Veterans Administration in Washington rejected the proposal on the grounds that a standard OMB rate of $39 per visit would have to be charged to the Navy, regardless of the fact that the use of the machine would have cost almost nothing to the San Diego Veterans Administration. The rate set by Washington turned out to be higher than the rate the Navy was paying in the private sector, thus, the Navy rejected the arrangement. The Navy has now bought its own laser at a cost of nearly $30,000.

"These witnesses testified that another proposed arrangement to share cardiac catheterization services failed for similar reasons. Also, in response to questions, it was disclosed that the Navy's $293 million hospital in San Diego is being planned with little or no coordination with the Veterans Administration. In radiation thereapy alone, the Veterans Hospital is spending $250,000 annually on private sector care. The new Navy facility is planning their own radiation therapy capability without regard for VA's needs in the area."

Mr. Chairman, in another area where sharing of resources is resorted to but at an untenable cost involves the Veterans Administration hospital here in Washington, D. C. This facility has no Computerized Axial Tomography Scanner, (CAT Scanner) of its own but contracts out for these services with the Washington Hospital Center, Welter Reed Army Medical Center, Georgetown University Hospital, George Washington University Hospital, Bethesda Naval Hospital and Sibley Hospital which is, obviously, the sharing of resources. However, the cost of these CAT Scans to the Veterans Administration hospital is over $400,000 a year, nearly the cost of a CAT Scanner. In addition, and not included in the more than $400,000, is the cost of ambulances to and from the CAT Scans and the fact that the patient must be accompanied by a registered nurse.

Mr. Chairman, on May 19, 1981 the House Veterans' Affairs Committee reported H.R. 3502, the "Veterans Administration and Department of Defense Medical Sharing Act," which was jointly referred to the Committees on Armed Services and Veterans' Affairs This legislation, a clean bill of companion measures supported by the V.F.W., provides for the greater coordination and sharing of medical facilities of the Veterans Administration and Department of Defense and establishes the VA as the primary back-up to the Department of Defense in treating casualties during periods of war.

Mr. Chairman, S. 266 introduced by the Honorable Charles H. Percy and co-sponsored by the Honorable William S. Cohen, the Honorable David F. Durenberger and the Honorable William Proxmire would establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of federal direct health-care resources and was referred sequentially to the Committee on Governmental Affairs and the Veterans' Affairs Committee.

As you are aware, there are presently nine Public Service Hospitals located in Baltimore, Maryland, Boston, Massachusetts, New Orleans, Louisiana, Norfolk, Virginia, San Francisco, California, Seattle, Washington, Staten Island, New York, Nassau Bay, Texas and a specialty hospital devoted to the treatment of Hansen's disease, commonly known as leprosy, in Carville, Louisiana and 27 clinics.

Mr. Chairman, the V.F.W. supports the Public Health Service hospital and medical care system which is under the jurisdiction of the Department of Health and Human Services and oppose its demise, as proposed by S. 1287 in the Senate and H.R. 3768 in the House. However, we cannot support the inclusion of its entire clientele into either the Veterans Administration health-care system or that of the Department of Defense, both of which are over burdened due to the shortage of health-care personnel. Although the PHS provides health-care for active duty and retired members of the United States Coast Guard and their dependents, the preponderance of those to whom health-care is furnished are civilians not entitled to care in either VA or DOD facilities as enunciated in 42 USC 249, 252, 253, 253(a), 253(b), 255 and 257. Furthermore, the V.F.W. has over the years fought the invasion of the VA hospital and medical care system by the Department of Health and Human Services formerly the Department of Health, Education and Welfare and, also, the splintering of Committee jurisdiction.

Presently the PHS also treats active duty and retired armed forces personnel on a reciprocal, space available basis just as armed forces health-care facilities care for active duty and retired Coast Guard personnel. This is a sharing satisfactory to all concerned. In addition, under the provisions of 42 USC 254a, the Public Health Service is authorized to share medical care facilities and resources with schools of medicine, hospitals and other health-care facilities with community health-care facilities on a reciprocal reimbursement basis.

Mr. Chairman, the Honorable Alan Cranston, the Ranking Minority Member of this Committee, has introduced an amendment to S. 636 the proposed "Veterans' Administration Health-Care Amendments of 1981" upon which the V.F.W. testified before this Committee on April 30, 1981, containing language identical to H.R. 3502, the "Veterans' Administration and Department of Defense Medical Sharing Act."

As previously stated, Mr. Chairman, the V.F.W. supports the provisions of H.R. 3502 and, therefore, Senator Cranston's amendment to S. 636. However, we would prefer the passage of the clean House bill rather than making the provisions thereof merely a portion of S. 636.

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

Senator MURKOWSKI. Mr. Philip Riggin.

TESTIMONY OF E. PHILIP RIGGIN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY ROBERT E. LYNGH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION

Mr. RIGGIN. Thank you, Mr. Chairman. Again, for the record, my name is Philip Riggin. I'm deputy director of the American Legion's National Legislative Commission. With me this morning is Robert Lyngh, who is director of our National Veterans Affairs and Rehabilitation Commission. He is prepared to summarize the Legion's prepared statement, with the understanding and the request that the entire statement be made part of the record. And, both of us will be available to respond to whatever questions you may have.

Senator MURKOWSKI. Thank you. Mr. Lyngh.

Mr. LYNGH. Thank you, Mr. Chairman. It's our pleasure and privilege this morning to represent the 2.7 million members of the American Legion to respond to the committee's consideration of pending legislation.

We commend to the committee consideration of our statement on S. 266 as also being to a great extent applicable to draft bill S. 636 as it regards sharing between VA and DOD. With reference to the provisions of S. 636 as appearing in Senator Cranston's amendment No. 62 providing for a contingency plan under which VA will provide medical resources to DOD in case of a military emergency, the American Legion is in general agreement with the need for such a contingency plan. We believe it is vitally important that once a costing formula is agreed on, reimbursement shall in each instance be to the facility providing services.

We further believe the act should include language that will prevent the Office of Management and Budget from adjusting VA fund allocations to allow for such reimbursement. Without such protective language we have every reason to believe that the Office of Management and Budget will undertake offsets against already under funded VA medical care appropriations.

We are concerned that no veteran with a service-connected disability should be deprived of treatment in a VA facility by reason of a VA/DOD contingency plan. We believe both the executive and legislative branches are subject to criticism for having allowed the military medical programs to have gotten into a situation in which they cannot handle even the initial casualty loads in the event of armed conflict overseas.

One final point, Mr. Chairman, if the Chair pleases, the American Legion is categorically opposed to any arrangement that would introduce merchant mariners, fishermen, or any other nonveteran categories into Veterans' Administration medical centers.

Thank you, sir.

Senator MURKOWSKI. Mr. Lyngh, I assume that the exception would be those people that are fishermen and are seamen and happen to be veterans?

Mr. LYNGH. That is correct, sir.

Senator MURKOWSKI. And, the fact that this particular group encompasses a very small number of beds, roughly 2,000 compared with 100,000, does not effect your general statement? You would oppose any inclusion, if there were excess facilities, even on an interim basis until those individuals either seek medical care through group programs or some other alternative; you would oppose that also?

Mr. LYNGH. Yes, Mr. Chairman, I realize that Congress is going to have a problem if the USPHS hospitals are closed, in determining what to do with that category of beneficiaries.

I would recall to the chairman's attention the comment by Dr. Custis just a bit ago to the effect that the Veterans' Administration is currently unable to deal with the caseload that's impacting on it by reason of the advancing age of the World War II veteran—the fact that you have now 9.5 million Vietnam generation veterans who are past the age of 32.

And, they're turning away veterans from both outpatient and inpatient care throughout the VA system. And, so there isn't any latitude as far as we can see for the introduction of another category of beneficiaries. In addition to which, the American Legion has a fundamental position. The Veterans' Administration medical care program was established to take care of the war veterans of the Nation. And, we would oppose any infringement upon that fundamental mission that has been given to the Veterans' Administration, in any case.

Senator MURKOWSKI. But, you would not oppose the DOD?

Mr. LYNGH. Well, we would not comment on that at this time, Mr. Chairman, we have——

Senator MURKOWSKI. Well, this is one of the points of this hearing, it's sharing concepts, the VA and the DOD. And, I think you have heard Senator Percy's comments this morning about a situation that exist in his State. And, would you oppose that sharing?

Mr. LYNGH. I would rather not commit the American Legion with reference to any position as far as admitting or accepting responsibility for merchant mariners, fishermen, or——

Senator MURKOWSKI. I'm not talking about merchant mariners or fishermen, I'm talking about the DOD——

Mr. LYNGH. Yes.

Senator MURKOWSKI [continuing]. And the veterans hospital, say in the case as outlined by Senator Percy this morning, where one facility has a lot of room in it, the other is relatively full and veterans may be having to go past the DOD facility to get to the veterans', and have to wait when the DOD facility could accommodate. This is—I think, the basis for——

Mr. LYNGH. They're talking about the Great Lakes situation, Mr. Chairman. I'd suggest that before the committee comes to any conclusions on that, they have an examination made of that Great Lakes naval facility because I understand that it's not in very good shape and not configured completely for the practice of modern medicine.

However, yes, our statement on S. 266 which we've submitted at length indicates that the American Legion is in general agreement with the fact that we support an increase in sharing between the two agencies as long as the primary mission of each is not interfered with, by all means.

Senator Murkowski. I think you clarified that, and I would appreciate for the record, any comments that you care to submit at a later date with regard to the recognition, as we all are, of the budget constraints and the realization that there are going to have to be some flexibilities extended with regard to the Government's role not to the veterans but to Public Health Service beneficiaries. May there be some reason for at least some temporary consideration of how this transition is going to occur with regard to the seamen and merchant mariners? That would be appreciated.

Mr. Lyngh. If any plan is put forward in that regard, sir, we would appreciate an opportunity to examine it and respond.

Senator Murkowski. I think the concern there is that it's been cut off; there has not been adequate time given for those individuals to seek alternative coverage. And, it may be that there would be some consideration in the DOD and the VA.

Mr. Lyngh. It's a genuine problem.

Senator Murkowski. Thank you, Mr. Lyngh. I think we're prepared to go on now.

[The prepared statement of Robert E. Lyngh and the American Legion's comments on the differences between S. 266 and amendment No. 62 follow:]

PREPARED STATEMENT OF ROBERT E. LYNCH, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion is pleased to have the opportunity to present its views on the bill the Committee has for consideration, S. 266, a bill to establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources.

Section 2 of the bill presents the rationale for legislation in the area of Federal medical resource sharing. The American Legion has no essential objection to the reasons set forth in the section.

However, section 2 presents the necessary opportunity for the Legion to bring more pointedly to the attention of the Committee the overriding factor that must be kept in mind in the development of any legislation looking to sharing of Federal health care resources. We refer to the specific missions of the Veterans Administration and of the Department of Defense. These are thoroughly different missions, and must not be lost in the establishment of any mechanism that looks to the sharing of resources - no matter how attractive the sharing of such resources may be, especially from the economic standpoint. The point here being that efficiency in cost expenditures, while a laudable goal, must not obscure the reason why the two health care programs have been established.

The existence of the Department of Defense health care institution predates that of the Veterans Administration, and extends as far back as the establishment of the United States Armed Forces at the time of the Revolution. As we understand it, the mission of health care in the Armed Forces is very simply to maintain a force fit to fight in defense of the national interest. All else that it does is subordinate to that, and if it does not do that, then it is of no use to the military.

Through the many years of its existence, the activities of the military medicine establishment have been broadened to include care for dependents of military members. This is all very good, but it is not the reason for which military medicine exists. We shall not discuss any confusion of mission within military medicine here, since that is not the purpose of the proposed legislation.

The mission of the Veterans Administration health care program, is of relatively recent origin in comparison with military medicine, but the VA health care program has, in 60 some years, become one of the most significant activities in the nation and indeed in the entire world, in the field of health care.

The primary mission of the VA health care program is to care for all those who were in any way disabled in the military service of the United States. Secondarily, by mandate of the Congress, acting for the American people, the VA provides a full range of health care services for all those veterans who need such care and who are not economically able to provide it for themselves. What has been accomplished by this mission of the VA is that war veterans do not have to entrust themselves to public charity for health care. This is a benefit provided by a grateful people in recognition of services rendered to the nation in its Armed Forces. We can assure the Committee it is a benefit highly treasured and jealously guarded by all veterans.

The overriding concern of The American Legion in the establishment of any health care sharing plan is that the separate and distinct missions of the two agencies not be lost in the doing.

If military hospitals cannot accept casualties because of veterans occupying beds, or if veterans medical centers cannot accept veterans who need care because beds are occupied by members of the military services, then the separated missions of the agencies will be defeated, and the different categories of beneficiaries will not be served.

Section 3 of the bill addresses another vital element of any sharing agreements. Paragraph 5 of section 3 reads: "negotiated cost" means the cost determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the services provided; --

We do not believe this plan will work as set forth in the section. What is needed is development of a costing formula that is satisfactory to both agencies. We believe this will have to be done agency to agency. We do not believe individual VA medical centers and individual military hospitals can set costing formulas on a station by station basis. Government health care delivery cannot be costed on any kind of formula that is used in the private sector. Such delivery is peculiar to itself; and there are major differences in the way health care is delivered as between military and veteran hospitals. In fact there are a myriad of elements that have to be taken into account in developing a mutually satisfactory costing formula. And this must be done before any sharing arrangement can be implemented.

Section 4 of the bill establishes a Federal Interagency Medical Resources Committee, to be composed of the Secretary of Defense and the Administrator of Veterans Affairs or their designees, and prescribes a methodology for the operations of the Committee.

The American Legion does not agree that the Secretary and the Administrator should constitute the Committee. The level of appointment is too high to operate easily, even through designees.

It is the recommendation of the Legion that the Committee should consist of the Chief Medical Director of the VA, and the Surgeons General of the separate military services. The reason for this is that these officers are best able to develop agreements and arrangements based on their individual capabilities systemwide, the availability of specific resources, and operating from an intimate knowledge of these elements. Such an arrangement would not only be more effective, but would complete and implement its work more expeditiously.

We do not believe the goal here sought lends itself to another Cabinet level Committee. In our judgment each and every element that will have to be dealt with in this matter will proceed with maximum benefit to all concerned through a Committee designed as here suggested.

With such a Committee in place, The American Legion has no difficulty with the methodology outlined in section 4.

We call attention, however to subparagraph (a) (7) (F) of the section, which reads: Reimbursement shall be credited when received by the providing agency to the specific facility that provided the medical service.

The American Legion strongly approves this provision of the bill, and considers it absolutely essential to the workability of the plan, and to the well-being of the individual stations of both VA and the military services.

However, here we must introduce another caveat into consideration of this proposal. And that is the possibility that OMB will take advantage of any opportunity involving cost sharing to automatically offset fund allocations to separate agencies, or elements thereof, to the extent that reimbursements are made. Such an OMB initiative could seriously impact on agency funding and, as concerns VA, would be totally unacceptable to the Legion.

We recommend the language of the legislation should prohibit any possible OMB initiative in this direction.

We also wish to point out to this Committee that the concept of sharing of Federal medical resources is not nearly so simple as it might seem to be at superficial consideration. We of The American Legion are well aware of that fact because we are working in veterans hospitals every day, and we have close and familiar knowledge of the needs and the stresses that go on in those institutions.

What we are saying is that in order for each agency to meet and fulfill its primary mission, each is subjected to requirements and constraints that do not always lend themselves to sharing. There are so many factors to this statement that they cannot all be mentioned here. Availability of professional staff in specific categories, is only one of a very great number of these factors.

There was, last year some publicity in the media, to the effect that veteran and military hospitals were sitting next to each other and duplicating expensive staff and equipment to the unnecessary cost of the taxpayers. Once again, we must say that the media doesn't always know what it is talking about. Had we been contacted before the stories were written, we could have helped in this area.

We can give the Committee an example of what we mean. Let us consider the VA Medical Center here in Washington, DC, with Walter Reed and Bethesda Naval right in the vicinity. Some would say right off there should be no need for a duplication of purchase of CAT Scanners for each of these hospitals. That may be so, but again, maybe not. What if all patients at VA had to be transported to Walter Reed for CAT Scan? Sounds reasonable. But what about the fact that many patients who need CAT Scan are in critical condition, and an ambulance trip could well be life threatening. Should their lives be endangered further to save some money? Or what about the fact that the possessor of the CAT Scan will naturally give its patients scheduling priority for use of the machine. What if a VA patient was scheduled several weeks in advance when the diagnostic procedure was critical to the length of the patient's life. Who sets the priorities in these matters - the possessor of the machine, or all of the potential users?

It can be seen from the illustration used here that the matter is not as simple as might appear upon superficial examination. And we must say that these factors and all others must, in the judgment of The American Legion be considered before conclusions are reached. We repeat again, that in all considerations and the resolution of all complex questions, the primary missions of each agency must be taken into account and satisfied.

There is one final point we wish to make with reference to the proposed legislation. We believe it should include a sunset provision. The reason for this is that the establishment of the Committee, with staff and the work it will be doing is going to involve considerable effort on the part of some very busy people who are in the service of the Government. This whole idea of the need for a sharing Committee may turn out to be a good one, or it may not. It is quite possible that the Executive Branch has inherent to its responsibilities and powers, sufficient authority to conclude such sharing agreements as may be feasible - given good will and cooperative attitude on the part of all concerned. It seems quite possible that the President can accomplish just about everything this legislation will hope to achieve, by issuing necessary orders to the agencies.

If that is so, and since we are living in these days with a proliferation of legislation, it is the recommendation of The American Legion that Congress, after enacting a law for the purposes here intended, take another look at the situation after two or three years, to determine whether the legislation is indeed necessary and useful.

Having commended all of the above factors to the attention of the Committee, we state again that we have no essential objection to the goal intended by the draft legislation.

We again thank the Committee for this opportunity.

The
American
Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

July 10, 1981

Honorable Alan Simpson, Chairman
Senate Committee on Veterans Affairs
410 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Simpson:

This is in response to your recent request for The American Legion's comments on the differences between S. 266 and Amendment No. 62 (to S. 636) concerning peace-time resource sharing. A comparison of the two measures reveals that S. 266 contains language which is too general in scope, lending itself to liberal interpretation. The language of Amendment No. 62, on the other hand, is more specific and would be less likely to allow an individual facility to stray too far from the intent of this legislation.

Amendment No. 62 would amend Title 38, U.S.C., incorporating the necessary provisions to implement resource sharing. These provisions would then serve as the guidelines for an interagency, oversight committee for the sharing of medical resources headed by the Chief Medical Director of the VA and the Assistant Secretary of Defense for Health Care. We view this as a more reasonable solution to a potentially complicated program which would be further complicated by the proposal of S. 266 to form a Federal Interagency Medical Resources Committee headed by the Administrator of the VA and the Secretary of the Defense.

We find the reimbursement provisions of S. 266 vague, saying that a negotiated cost will be credited to the facility which provided the Service. Amendment No. 62, however, clearly states that a costing methodology will be established, providing reimbursement which will be credited to the appropriation and to the facility which provided the services. This language is preferable mainly because it will establish a cost formula which will prevent any single facility from comparing its costs with private sector costs.

The above discussion of the differences between S. 266 and Amendment No. 62 (to S. 636) has addressed only the peace-time provisions of these measures as you requested. We hope this comparison has served to provide a clearer understanding of the Legion's position on the matter.

Sincerely,

E. Philip Riggin, Director
National Legislative Commission

Senator **MURKOWSKI**. I am going to call on Mr. Gabriel Brinsky, the national service and legislative director of AMVETS. Welcome, Mr. Brinsky.

TESTIMONY OF GABRIEL P. BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS

Mr. **BRINSKY**. Thank you, Mr. Chairman.

AMVETS appreciates this opportunity to appear before the committee to express its views on S. 266. In our view, under proper restraints the sharing of resources between the Department of Defense and the Veterans' Administration is good economics and administration. We believe that there is a special relationship between these two agencies born of a common purpose.

AMVETS fully shares the views previously expressed by Senator Mitchell of this committee that the health care cost of our veterans is a continuation of the cost of waging war. Therefore, by reason of this close kinship, it is only natural that a sharing relationship be established but a sharing relationship which will not impede or restrain the obligations of the providing agency as established by mandates of Congress.

AMVETS unequivocally and enthusiastically supports the concept of amendment No. 62 to S. 636, which would grant the Administrator of Veterans' Affairs, during a period of war or a period of national emergency declared by the President or the Congress to provide hospital care to the members of the Armed Forces under certain conditions.

We view this as a natural extension of the VA health care system. Not only because of the kinship, but because of the consanguinity encountered in their medical health care system. While we believe that the civilian sector of the health care program may be called upon to make a contribution in the event of an emergency or crisis, we are convinced that the principal role for caring for the wounded, rests with the Department of Defense and the facilities made available through the Veterans' Administration.

We are further convinced that unless a viable VA hospital and health care program is maintained, those who are called upon to serve at a subsequent date will bear the brunt of the burden for our having failed to do so.

To conclude, AMVETS supports the provisions of S. 266 and strongly favors section 2(4) of H.R. 3502 or, in the alternative, amendment No. 62.

Thank you.

Senator **MURKOWSKI**. Thank you, Mr. Brinsky.

[The prepared statement of Gabriel P. Brinsky and AMVETS comments on the differences between S. 266 and amendment No. 62 follow:]

STATEMENT OF

GABRIEL P. BRINSKY
NATIONAL SERVICE & LEGISLATIVE DIRECTOR AMVETS

Before The
COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

WASHINGTON, D.C.

June 17, 1981

AMVETS appreciates this opportunity to appear before the Committee to express its views on S-266.

My comments will be short and it is requested that my full statement be incorporated with the records. This Bill would establish a Federal Inter-Agency Medical Resources Committee comprised of the Secretary of Defense and the Administrator of Veterans Affairs with a view of hearing interagency medical resources. Recently there was a disclosure in the printed media which demonstrates the desirability of an interagency sharing between the Department of Defense and the Veterans Administration. The incident cited was the use of a VA psychiatrist by the Department of Defense which had the need of the psychiatrist only on a part-time basis. The sharing of the services of this medical professional was terminated when the question arose as to whether or not there was authority to "loan" the psychiatrist to the Department of Defense.

It is AMVETS view, that under proper restraints, the sharing of resources between the Department of Defense and the Veterans Administration is good economics and administration. And we believe that there is a special relationship between these two agencies born of a common purpose. AMVETS fully shares the views previously expressed by

Senator Mitchell of this Committee that the health-care cost of our veterans is a continuation of the cost of waging war. Therefore, by reason of this close kinship, it is only natural that a sharing relationship be established but a sharing relationship which will not impede or restrain the obligations of the providing agency as established by the mandate of Congress.

AMVETS unequivocably and enthusiastically supports Section (2)(g) of HR-3502 which would grant to the Administrator of Veterans Affairs during a period of war or a period of national emergency declared by the President or the Congress to provide hospital care to the members of the Armed Forces under certain conditions. We view this as a natural extension of the VA Health Care System. Not only because of their kinship, but because of the consanquinity encountered in their medical health care system. While we believe that the civilian sector of the health care program may be called upon to make a contribution in the event of an emergency or a crisis, we are convinced that the principal role for caring for the wounded rest with the Department of Defense and the facilities made available through the Veterans Administration. We are further convinced that unless a viable VA hospital and health care program is maintained, those who are called upon to serve at a subsequent date will bear the brunt of the burden for our having failed to do so.

To conclude AMVETS supports the provisions of S-266 and strongly favors Section (2)(g) of HR-3502.

Thank you.

S-266 would establish a Federal Inter-Agency Medical Resources Committee to facilitate sharing of medical resources between the Veterans Administration and the Department of Defense. The Committee would be composed of the Secretary of Defense and the Administrator of Veterans Affairs or their designees. Amongst its purposes would be to review existing Veterans Administration and Department of Defense direct health care capabilities, including support and administrative services, to identify sharing opportunities that will not adversely affect the quality of, or the established priority of, care provided. It would also coordinate the establishment of uniformed interagency health care policies and procedures for providing agencies and monitor the implementation of such policies and procedures, including policies and procedures for coordinator planning for future development of each agency's direct health care delivery system. The negotiation of medical resources to be shared would be negotiated by the Directors or the Commanding Officers of the health care facilities entering into an arrangement. Under such arrangements, a beneficiary eligible for direct health care in one agency's facility could receive medical care at a providing facility of the other agency. The availability of direct health care to beneficiaries of an agency other than the providing agency would be on a referral basis, and would not, as determined by the Directors or Commanding Officers participating in such arrangements, adversely affect the quality of care and priority access for medical services of the providing agency's beneficiaries. There is provision for reimbursement which would be credited when received by the providing agency to this specific facility that provided the medical service.

This Bill is similar in many aspects to S-2613 which was considered in the Senate by the 96th Congress. It is similar in many regards to

HR-3502 which was introduced in the 97th Congress. One major difference in the provision in HR-3502 in Section (2)(g) which provides that notwithstanding any other provision of the Title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in an armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and medical services under Chapter 17 of this Title to members of the Armed Forces on active duty, as authorized by this Section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities. The Administrator of Veterans Affairs is authorized to contract with private facilities for such facilities of hospital care and medical service to treat a condition for which a veteran is receiving medical services under Sub-Section (f) or (g) of Section 612 of Title 38 in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition. It would also provide hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of the veteran eligible for such care or services under Chapter 17 of Title 38 if Veterans Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under the conditions related.

AMVETS favors the concept of Section (2)(g) of HR-3502 which would provide for arrangements being made between the Veterans Administration and the Department of Defense to share medical facilities. We have traditionally considered the Veterans Administration Health Care Program as a backup to the needs of the Department of Defense in time of national emergency or a period of war.

We also feel that it is desirable both economically and managerially to share medical resources but within certain confines such as between the Veterans Administration and the Department of Defense. We are of the view that such sharing can be accomplished without impairing the goal of the Veterans Administration Health Care Program which is to provide quality care to the disabled veteran. This would not be true if the concept of sharing was further extended to include other agencies. For example, it is not considered feasible for any substantial sharing with the Department of Health and Human Services by reason of incompatibility of objectives.

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GABRIEL P. BRINSKY
NATIONAL SERVICE AND
LEGISLATIVE DIRECTOR

July 6, 1981

Senator Alan K. Simpson, Chairman
Committee on Veterans Affairs
United States Senate
Washington, DC 20510

Dear Senator Simpson:

I have your letter of June 26 relating to the hearing held by your committee on proposed legislation designed to facilitate sharing of medical resources between the Department of Defense and the Veterans Administration.

Senator Alan Cranston has submitted an additional question. He solicits any detailed comments we may have on the differences between S. 266 and Amendment No. 62 (to S. 636) in regard to their respective provisions for peacetime sharing.

We preceive no significant difference in substance between the two bills.

S. 266 would establish an interagency medical resources committee composed of the Secretary of Defense and the Administrator of Veterans Affairs or their designees. In all probability, the "designees" would be the Chief Medical Director of the Veterans Administration and the Assistant Secretary of Defense for health affairs. Amendment No. 62 (to S. 636) specifically provides that the interagency committee be composed of the Chief Medical Director of the Veterans Administration and the Assistant Secretary of Defense for health affairs.

Under the provisions of S. 266, the committee would be required to establish prescribed uniform guidelines within six months whereas Amendment No. 62 would allow a period of one year. In the absence of any reason for time being of the essence, it may be desirable to allow as much time as possible and therefore we favor the one year period.

Thank you for allowing us to express our views.

Very truly yours,

Gabriel P. Brinsky
National Service and Legislative Director

"A time of change . . . A year of challenge."

Senator **Murkowski**. I call on Mr. John Heilman—excuse me—Rick. OK, Mr. John F. (Rick) Heilman, national legislative director, Disabled American Veterans.

TESTIMONY OF JOHN F. HEILMAN, NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. **Heilman**. Yes sir, Mr. Chairman, good morning. You may recall, sir, in February of this year when our national commander appeared before the full Veterans' Affairs Committee——

Senator **Murkowski**. I do recall.

Mr. **Heilman**. We did solicit your committee to consider legislation that would authorize and promote a more statutorily defined relationship between VA and DOD in terms of health care sharing. We did this because we recognized that it would promote a more judicious expenditure of Federal dollars and because we realized that the VA should be considered and is needed as a primary backup to the military in case of future war or national disaster.

And, quite frankly, because we view it as a way of stopping the erosion that has occurred in recent years in our VA hospital system in terms of bed losses and health care personnel losses. With respect to the pending bill, S. 266, that addresses the subject of peacetime sharing. Again, obviously, we support this basic concept.

There is one major objection that we have to S. 266, and that is, it brings into play other Federal providers into such issues as health care sharing, expansion, construction, and location of medical facilities in the system, and by that, I mean VA and DOD. And also brings them into play in terms of policy and procedural matters relating to VA health care.

When we talk about other Federal providers, obviously we're talking about HHS. Our organization objects very vehemently to having HHS intrusion into the VA hospital system on any level.

Senator **Murkowski**. Excuse me—could you elaborate why? I've gathered and sensed that was the case—they want to keep Health and Human Services at more than arm's length from either the VA or the DOD health care.

Is it any reason—the quality of research or care or programs or operations——

Mr. **Heilman**. Sir, at the risk of——

Senator **Murkowski**. I'd appreciate your frank opinion.

Mr. **Heilman**. Right, yes—many people think that the DAV or the veterans organizations in general are paranoid in this respect. We believe that HHS is blatantly antagonistic toward maintaining an independent VA hospital system as a sole Federal provider of health care for veterans.

We believe HHS would like to see the VA hospital system cease to exist. A recent example of HHS intrusion occurred last year in Minnesota relating to the proposed construction of a new VA hospital system in Minnesota. The local health systems agencies, the HSA's who are related intimately to HHS, put on a very heavy lobbying effort to reduce the size of the proposed hospital that was under consideration, solely because they claimed that the private sector in that metropolitan area had sufficient beds to provide health care for veterans.

Quite frankly, they were overbedded. Action was taken to get a Member of the House to—in committee to in fact reduce the size of the proposed hospital system. Subsequently, on the floor, the original size of the proposed hospital was put back.

This is the type of thing that we fear in terms of getting HHS involved in policy, procedure, issues that determine where new hospitals will be built—if a new hospital will be built—improvements in existing facilities—we believe HHS would be basically promoting their fundamental belief that in the big picture there is not a need for continuation of an independent VA hospital system.

Quite frankly, sir, that's why we're opposed to it.

Senator MURKOWSKI. No telling what kind of a response Public Health would have if they were here and responding to the same question.

Mr. HEILMAN. Well, my remarks—these remarks, of course, are referring to HHS; now Public Health Service hospitals are the responsibility of HHS.

Senator MURKOWSKI. I think you've answered. I can understand.

Mr. HEILMAN. If I could make one more point.

Senator MURKOWSKI. Go ahead.

Mr. HEILMAN. I do wish to say that as you noted, the administration witnesses in essence came over here with a nonposition. Quite frankly we're not surprised with that fact. And, by saying that I cast no aspersions on the witnesses themselves, especially on Dr. Custis, who the DAV holds in high admiration.

However, their testimony is passed on by OMB. And, OMB has been primarily responsible for the wounds that have been inflicted on the VA hospital system in recent years in terms of proper maintenance of the system, beds, health-care personnel.

So, it's not surprising to us that OMB would require them to come over here and in essence give a no position. Because how could they do otherwise in terms of supporting this legislation which clearly recognizes the value of the VA hospital system as a national resource. If it's imperative that DOD be backed up, and it is, and we believe it is, and that the VA is the logical agency to provide this backup, how could OMB come over here and admit that fact and yet continually in terms of their budget request of the Congress—and I want to state that this includes prior administrations as well as this administration. How could they continually push for diminishment of VA health care, VA health-care resources and at the same time strongly support legislation that would require VA to maintain its viability as a health-care system. So, we're not surprised about that at all.

I just finally want to say that we do support amendment No. 62 to S. 636, that relates to both issues of emergency contingency planning and the peaceful sharing of resources. We think that's the proper vehicle and we urge the committee to favorably consider it.

Senator MURKOWSKI. Thank you, Rick Heilman. Your remarks are appreciated and considered by the committee.

[The prepared statement of Mr. John F. Heilman and the Disabled American Veterans comments on the differences between S. 266 and amendment No. 62 follow:]

PREPARED
STATEMENT OF
JOHN F. HEILMAN
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
TO THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
JUNE 17, 1981

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 696,000 members of the Disabled American Veterans, may I say that we appreciate this opportunity to present our views on legislation relating to federal programs of health care benefits and services for America's sick and disabled veteran population.

S. 266 & A Proposal Similar to Section (2)(g) of H.R. 3502

Mr. Chairman, though S. 266 and the above cited proposal each espouse a separate and distinct goal, I shall discuss them in concert, for together they address the subject of, and would alter the relationship between, health care facilities administered by the Department of Defense and the Veterans Administration.

S. 266, entitled The Federal Interagency Medical Resources Sharing and Coordination Act of 1981, was introduced in the Senate on January 27, 1981 by Senator Percy and is cosponsored by Senators Cohen, Durenberger and Proxmire. The goal of this measure is, via the creation of a Federal Interagency Medical Resources Committee composed of the Secretary of Defense and the Administrator of Veterans Affairs (or their designees), to promote and insure the most efficient and effective use of interagency sharing of medical resources between the Veterans Administration and Department of Defense.

S. 266, as you are aware, is very similar in intent and purpose to S. 2958, a bill that was introduced by Senator Percy last year during the Second Session of the 96th Congress and which was, in fact, given Senate approval. The pending bill is also similar in basic intent to Section 2(a) through (f) of H.R. 3502.

Section 2(g) of H.R. 3502, through appropriate amendment of Title 38, USC, proposes to authorize the Veterans Administration to provide medical care on a priority basis to members of the Armed Forces who are injured during a period of war or national emergency. This proposal, as indicated in your letter of invitation to testify, has been considered and recently ordered reported by the House Veterans Affairs Committee (as a provision of H.R. 3502).

Mr. Chairman, with respect to the pending legislation, you may recall that our National Commander, in his recent, formal presentation of DAV 1981 legislative goals to the Senate Veterans

Affairs Committee, addressed the subject of Veterans Administration/Department of Defense emergency health care contingency planning and the coordinated use of VA/DOD medical resources.

As he pointed out at that time, during the Vietnam Conflict, the VA assumed a substantial portion of DOD's health care case load through the treatment of severely disabled battlefield casualties who were not expected to be returned to active military duty.

Noting that recent studies have shown that the military would once again be forced to rely on VA medical facilities in the event of a future war, your Committee was solicited by our Commander to seriously consider legislation that would authorize and statutorily define VA/DOD emergency health care contingency planning.

The proposal contained in Section 2(g) of H.R 3502 would do just that.

Specifically, it would authorize that, during a period of war or a period of national emergency declared by the President or the Congress which involved the use of the Armed Forces of the United States, the VA Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of health care services to members of the Armed Forces than to any other group of persons eligible for such medical services, with the exception of veterans with service-connected disabilities.

Mr. Chairman, we wholeheartedly approve of and support this proposal, particularly its provisions which protect the eligibility, priority and quality of care now afforded to the VA hospital system's primary beneficiary--the service-connected disabled veteran. We also note this protection is further buttressed by a provision which authorizes the VA Administrator to contract with private facilities for the furnishing of medical services to service-connected veterans in the event that this should become necessary during any period of emergency utilization that has been authorized by the President.

However, we do have one suggestion in the form of an amendment to this proposal, which we believe to be vital if the fundamental purpose of the measure is to be achieved.

Mr. Chairman, we are all familiar with the state of decline that has befallen our VA hospital system in recent years--a decline precipitated by the fiscal recommendations and policies of the Office of Management and Budget. It is not my intention to use today's hearing for the purpose of describing the wounds inflicted upon VA health care by the Office of Management and

Budget. However, there is one OMB-caused salient fact that I wish to draw to your attention:

If something is not done to combat the hospital bed losses that have occurred in our VA hospital system, and which will continue to occur if OMB has its way, the legislation you are considering today will surely become a "moot point," even if it is enacted into law.

The Veterans Administration began the decade of the 1970's with over 104,000 hospital beds; by the end of that decade, 20,000 of those beds were lost.

Mr. Chairman, in the last four years alone, the VA has suffered a 15,000 health care bed loss--that is the equivalent of removing 30 500-bed hospitals from the system.

The Congress, generally, has resisted the proposed bed reductions of OMB--witness the recent Congressional action on the First Concurrent Resolution on the Budget. However, the Congress has not always been successful. If these losses are allowed to occur or continue to occur, our VA hospital system will eventually be "squeezed to death." We simply will not have the bed space necessary to accommodate the goals specified in the pending legislation.

We therefore recommend that the Committee give serious consideration to statutorily requiring that the Veterans Administration have on hand, at all times, a specified minimum number of fully staffed operating beds.

Noting that in Fiscal Year 1980 there were 84,145 beds in the system with an average daily inpatient census of 68,109, and being mindful of the 1965 VA/DOD interagency agreement which specified that 20,000 VA hospital beds would provide the necessary supplemental assistance for (VA) treatment of battlefield casualties, we recommend that 90,000 operating beds be specified as the minimum number below which the VA cannot go.

If such a number was so specified, and if the arbitrary "caps" now being placed on VA projections of outpatient and inpatient treatment levels were to be removed, consumer demand on the system would more than assure that appropriate bed occupancy rates would be maintained. Indeed, considering the projected future health care needs of our aging World War II veteran population, VA will be hard pressed to fulfill its mission with a 90,000 bed system.

In line with this recommendation, it is of course pertinent to note that a specific statutory minimum bed level requirement for the VA health care system is contained as a provision of

H.R. 3499, The Veterans Administration Health Care Act of 1981, which has recently been passed by the House of Representatives (June 2, 1981).

Mr. Chairman, we urge the Committee to give serious consideration to such a minimum bed level requirement.

With regard to the pending bill S. 266, may I state, Mr. Chairman, that the Disabled American Veterans does support the basic concept of the measure. That is to say, we do believe that a broader, more comprehensive sharing arrangement between medical facilities of the Veterans Administration and the Department of Defense is desirable--both from a standpoint of (1) promoting the most judicious expenditure of federal health care dollars and (2) reinforcing and complementing the VA/DOD "backup" relationship contemplated by the previously discussed legislation.

Our support of such an expanded relationship is, of course, contingent upon the premise that no violation would be done to the quality and extent of care now provided to VA health care beneficiaries nor to the agency itself, in terms of its basic health care mission--acting as the sole, primary federal provider of medical care to our nation's veteran population.

This statement of support and qualifying reservations have been provided by our organization to Senator Percy and his staff, as well as to the House Veterans Affairs Committee.

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Having said this, Mr. Chairman, I can state that there is one aspect of S. 266 which makes the measure unacceptable to the Disabled American Veterans--the inclusion of language, specifically Section 4(a)(6) and Section 4(a)(7)(A), which direct VA and DOD to consult with other federal health care providers on issues such as; interagency health care sharing, proposed construction and location of medical facilities and health care policies and procedures.

Of course, the only other federal provider of health care (of any consequence) with whom the Veterans Administration and Department of Defense could consult is the Department of Health and Human Services.

Mr. Chairman, our organization has in the past and shall in the future strongly oppose any administrative or legislative proposal that would extend to the Department of Health and Human Services any type of policy making/procedural role relative to the delivery of veterans' health care benefits and services.

Without going into great detail, it should be pointed out that HHS, unlike the VA and the military, does not operate a comprehensive, nationwide system of medical facilities that provide direct health care services to a significantly large number of consumers (the eight Public Health Service Hospitals notwithstanding). In our opinion, HHS would have little to offer (to the VA and military) in terms of "sharing" health care facilities.

Also, the Medicare/Medicaid "track record" of HHS leaves much to be desired vis-a-vis the efficient and responsible management of federal health care funds. We see no valid reason to give HHS the opportunity to "practice its art" in the VA health care system.

Lastly, we find absolutely abhorrent the prospect that HHS might have a substantial role in matters that determine the mission and future expansion of our VA hospital system. At best, that agency is indifferent to the special health care needs of veterans. At worse, it is blatantly antagonistic. We do not believe HHS should be given one iota of influence in any program of the Veterans Administration.

We therefore recommend and urge that any VA/DOD health care sharing legislation the Committee may act favorably upon be completely devoid of any reference to federal health care providers other than the Veterans Administration and the Department of Defense.

* * *

This completes my statement Mr. Chairman. We appreciate having been given the opportunity to testify today and we also wish to thank you and the members of the Committee for taking the initiative to hold Congressional hearings on these most important subjects.

* * * *

DAV

Motto: "If I cannot speak good of my comrade, I will not speak ill of him."

DISABLED AMERICAN VETERANS

NATIONAL SERVICE and LEGISLATIVE HEADQUARTERS
807 MAINE AVENUE, S.W.
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July 2, 1981

DAV RESPONSE TO THE FOLLOWING QUESTION:

> Please provide any detailed comments you might have on the differences between S. 266 and Amendment No. 62 (to S. 636) in regard to their respective provisions for peacetime sharing.

As indicated in our written testimony and as amplified upon during our oral remarks, we perceive the major difference between S. 266 and Amendment No. 62 (to S. 636) in regard to VA/DOD peacetime sharing of medical facilities to be as follows:

> S. 266 contains language that would direct the Veterans Administration and Department of Defense to consult with other federal health care providers on issues such as interagency sharing, proposed construction and location of medical facilities and health care policies and procedures.
>
> Amendment No. 62 (to S. 636), with regard to the issue cited above, does not contain any reference to federal providers of health care other than the Veterans Administration and the Department of Defense.

At the risk of being repetitious, let me again state that the DAV is very much opposed to giving any other federal health care providers--especially the Department of HHS--any influence over our VA hospital system.

We therefore recommend and urge that any VA/DOD health care sharing legislation the Committee may act favorably upon be completely devoid of any reference to federal health care providers other than the Veterans Administration and the Department of Defense.

Senator MURKOWSKI. I would like to thank the other members of the panel. I note that the order of presentation departed from the conventional manner in which the protocol is structured. I apologize for this and we will correct that.

Mr. RIGGIN. Mr. Chairman.

Senator MURKOWSKI. Yes.

Mr. RIGGIN. May I make two comments in response to two of your questions. It will be very brief.

First of all in partial response to your question to Mr. Heilman regarding our concern over HHS involvement with the VA hospital system. I think that one of our primary concerns has been, for quite sometime, that the—that a national health insurance system which may be established as recommended by a variety of people over the last decade would of course be administered by the Department of Health and Human Services.

Those who espouse a national health insurance system have looked with interest at the VA hospital systems during that period of time. I think that really is the bottom line concern of veterans organizations generally. And, any action that we see moving toward that is the real concern of ours.

In response, in partial response to your question regarding PHS beneficiaries and what to do with them during the transitional period, in view of the imminent shutdown of the PHS system. I think that it might be worthy of this committee's consideration and congressional consideration generally of a vouchering of those people into the private health facilities during this interim period, simply providing care in a private facility and having the Federal Government picking up the tab for it. This in some fashion or another is a system that should be put into effect very quickly without moving into the areas where we have already expressed our concern in VA or DOD.

It's something worth considering.

Senator MURKOWSKI. Do you have any idea in your opinion what the availability is in the private sector of those hospitals that have the type of facilities which would be comparable to Public Health Service hospitals?

Mr. RIGGIN. That would be something we'd have to, obviously investigate, it's something we haven't come here this morning to respond to. But, it's clear that a lot of metropolitan areas are talking about overbedding in private facilities. Mr. Heilman made reference to the Minneapolis case. There is a similar circumstance in Baltimore, Md., where a PHS facility is being shut down.

Senator MURKOWSKI. You say overbedding?

Mr. RIGGIN. In the private sector.

Senator MURKOWSKI. So they have too many beds?

Mr. RIGGIN. Yes, sir.

Senator MURKOWSKI. Empty beds?

Mr. RIGGIN. Yes, sir, 130,000 nationally, Mr. Chairman. So it's something to consider. And, it can be done I think without changing any legislative mandate. It can be put into operation in a relatively quick period of time.

Senator MURKOWSKI. The position officially of DOD and the veterans groups toward utilizing those beds is specifically what?

Mr. RIGGIN. I'm sorry, sir——

Senator MURKOWSKI. Too many beds in the private sector that you referred to.

Mr. RIGGIN. Well, that's a private sector problem, sir.

Senator MURKOWSKI. No; I'm asking you—what is the position in—if you need more beds, and you don't have them in the veterans or the DOD, utilizing those beds?

Mr. RIGGIN. Well, we'd like to have additional appropriations to expand the VA hospital facilities.

Senator MURKOWSKI. I recognize that, my question is in the event that you need the beds, and you don't have the facilities, can't build brick and mortar overnight, do you have any interest or is there any provision to utilize the beds?

Mr. RIGGIN. In private facilities, we've testified on various occasions of our general opposition to doing something like that, sir—of vouchering veterans into a private facility and having the Federal Government pay for it.

Senator MURKOWSKI. Even if they are closer to their homes?

Mr. RIGGIN. Well, hopefully, this sharing would resolve part of that, sir.

Senator MURKOWSKI. Solve part of the problem, granted.

Mr. RIGGIN. Yes, sir.

Senator MURKOWSKI. But, I'm concerned with the realities of budget, the budget problem. There is a time element involved in building new facilities. The fact that if you have a high number of beds in facilities that can provide the type of care that is adequate and that veterans are entitled to——

Mr. SCHWAB. Mr. Chairman, we have not faced that problem.

Senator MURKOWSKI. I beg your pardon?

Mr. SCHWAB. We have not faced that problem and it doesn't appear that we will.

Senator MURKOWSKI. You don't feel you're at that point now?

Mr. SCHWAB. The VA has maintained from 16,000 to 20,000 empty beds on a monthly basis.

Senator MURKOWSKI. I understood by the testimony that the occupancy was much higher than that.

Mr. SCHWAB. No; they run from 16,000 to 20,000 empty beds and run about 80 percent occupancy for several reasons. The medical process of handling patients in bed has shortened stays. Advances in medical science have shortened stays and also because of the starvation of funds and personnel, particularly during the last 4 years, the cutback in personnel has caused the VA to turn away, not only non-service-connected veterans but veterans with service-connected disabilities because of the lack of personnel to operate beds.

As a matter of fact, 30 wards were closed because of a lack of registered nurses.

Senator MURKOWSKI. Not enough personnel; not because you couldn't fill up the beds. You could fill up the beds if you had the personnel?

Mr. SCHWAB. Well, we believe they could, yes, sir. But, we have never been faced with a bed shortage in the VA hospital system since I've been exposed to it.

Senator MURKOWSKI. So again, in spite of the fact that you have empty beds, so to speak, and you're running at 80 percent, you would still prefer to see the Public Health Service obligation moved to the private sector?

Mr. SCHWAB. Well, sir, if you bring the Coast Guard personnel into the VA and DOD systems wholly, and their eligible dependents, we have no objection and also those civilians in the merchant marines, who would be eligible for VA care anyway, it would serve quite a few, but it wouldn't absorb—and we don't want in the VA system, the broad universe of civilians the PHS treats, including aliens, those sent for the drug cure by court order—foreign seamen, fishermen on vessels who aren't merchant mariners and veterans but just fishermen on commercial vessels, no sir.

Mr. RIGGIN. Mr. Chairman, my reason for making that reference to vouchering in a private system was simply in specific response to your question regarding a transitional period, not necessarily a position that I or my organization would adopt. In fact, we have no position on it, it's just simply something for committee consideration.

Senator MURKOWSKI. Well, we obviously don't have enough information here with regard to what the real need is as it pertains to the Coast Guard or the fishermen or the merchant seamen or the alternatives. But, I think, at least its been kicked around and there is going to be some consideration and perhaps some factual figures will be given.

I just might mention with regard to the reference to the administration and national health insurance—I was pleased that you used the word may because that's my contention, that it's not anything more than may.

Mr. RIGGIN. That's right, sir, I did not intend to suggest that it was an obvious——

Senator MURKOWSKI. I was sure, I just wanted to make sure that we were both on the same wavelength.

I would remind all witnesses that Senator Cranston and perhaps other Senators will have written questions for the record. I think that the presentations given by the various witnesses here today will be most helpful to our chairman, Senator Simpson, and the other members of the committee. I commend you for your participation and with that we conclude the hearing.

I'll leave the record open for 7 days. Thank you, gentlemen, have a good afternoon.

[Whereupon, at 12:23 p.m., the hearing was adjourned.]

PARALYZED
VETERANS
OF
AMERICA
CHARTERED BY THE CONGRESS OF THE UNITED STATES

July 6, 1981

Honorable Alan K. Simpson, Chairman
Senate Committee on Veterans' Affairs
410 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Simpson:

On June 17, 1981, a representative from Paralyzed Veterans of America attended a hearing conducted by the Senate Committee on Veterans' Affairs. The hearing was chaired by the Honorable Frank Murkowski and addressed S. 266, a proposal which would establish a Federal Interagency Medical Resources Committee. PVA has communicated on several occasions with Senator Charles Percy, sponsor of S. 266, and we addressed it before the House Committee on Veterans' Affairs on March 25, 1981. PVA has given considerable attention to the possible sharing of medical facilities by the Department of Defense and the Veterans Administration, and we support the proposed arrangement, providing it exists on a limited basis.

PVA agrees with Senator Percy's efforts, so long as the VA continues to provide needed services to veterans and is expanded to care only for active duty military personnel. We do not wish for the VA system, with its restrictive budget, to be opened to military dependents or beneficiaries of other federal systems. Furthermore, even if the VA's budget were greatly increased, the VA system is meant to provide health and medical services to the particular needs of veterans. To dilute this specialized care would be to undermine the system designed to care for illnesses and injuries which arise because of military service.

It is doubtful that there will be a significant increase in funding for the VA's Department of Medicine and Surgery in the foreseeable future. And, there are too few available beds in the VA system to serve a clientele larger or more diverse than the existing one, with the possible exception of the limited number of Department of Defense personnel who would utilize VA facilities.

Senator Murkowski asked a number of very relevant questions during the hearing on S. 266. In effect, he sought to discern if there exist VA hospital beds which can be shared with Department of Defense personnel. Veterans representatives generally responded that such excess beds do exist. If underutilized VA beds exist, he then wanted to know, why do veterans organizations so often state that there is a shortage of VA hospital beds to care for the nation's veterans.

The Senator asked these questions in an effort to ascertain the availability to veterans of VA health-care services, to include the adequacy of VA hospital beds and specialized medical equipment. PVA sincerely appreciates Senator Murkowski's probing questions and his concern for the health and medical needs of veterans.

4350 East-West Highway, Suite 900, Washington, D.C. 20014 (301) 652-2135

The questions posed were not satisfactorily and completely answered. PVA must state that, system-wide, the VA has a limited number of beds in excess of those which are in continuous average daily use: within some geographic locations there are severe shortages of hospital beds. In PVA's Annual Legislative Statement before the Senate Committee on Veterans' Affairs, which was presented on April 2, 1981, we asked for more thorough, long-term planning to be utilized by and on behalf of the VA:

> This Committee and the Veterans Administration have made great efforts to provide adequate equipment for the VA's Department of Medicine and Surgery. We know that the Office of Management and Budget has, for example, refused to provide the VA with funding for the purchase of CT scanners. OMB's argument has been, most recently, that the VA's request was made hastily and that insufficient planning had gone into accurate placement of this very expensive equipment. (pp. 26-27)

PVA then asked that the VA be directed to conduct a demographic study of the patient origins of veterans who have made use of CT scanners and hemodialysis machines, as examples of the need to examine accurate placement of very costly medical items.

The same problems which surround the VA's placement of machinery also hampers the accurate locations of VA facilities. The veterans population has begun to concentrate in different areas from when most existing VA facilities were constructed, and veterans in states such as Florida have experienced severe bedding shortages in VA facilities. For example, the VA was unable to care for veterans who were already patients in its facilities and at the same time provide treatment for a small number of Cuban refugees who required emergency hospitalization. These facilities stay at near full capacity with veterans, and very little room exists for sharing with possible beneficiaries of other health-care programs.

Similar demographic changes have affected the Department of Defense. Senator Percy often refers to an excess of DOD hospital beds in the Chicago, Illinois, area, while the antiquated VA facility there is overcrowded. This problem has arisen because of what appears to be short-sighted planning, in that the Naval Training Center has re-located to Florida, rendering the DOD hospital in Chicago virtually useless. Furthermore, there is in New Orleans, Louisiana, the F. Edward Hebert Naval Hospital which, like the one in Chicago, serves little or no useful purpose, because there are not enough DOD personnel in the surrounding area to warrant such a facility.

An additional source of the improper location of VA and DOD health-care facilities, besides changing population characteristics, is that Members of Congress have too often used these construction projects for political objectives. For example, a Member of the House of Representatives recently opposed the construction of a new and badly needed VA hospital in Baltimore, Maryland, because his District contains the existing dilapidated VA hospital which would be closed upon opening of the new one.

Honorable Alan K. Simpson, Chairman
Senate Committee on Veterans' Affairs
July 6, 1981
Page Three

PVA's Annual Legislative Statement noted, additionally, that within the VA health-care system, specialized medical centers have not been accurately located to provide veterans with timely care. We pointed out that the VA's Spinal Cord Injury Program, with which PVA is intimately aware, needs an SCI center in the Mountain or western Great Plains States. (pp. 22-25) The VA has 1,365 SCI beds but recognizes that it will require at least 1,845 beds by Fiscal Year 1985. In addition to this pending shortage of SCI beds, spinal cord injured veterans who live west of the Mississippi River must travel great distances if they need treatment in a VA SCI center. As the attached map clearly shows, VA SCI beds are located so that overuse exists in certain areas, and any existing underutilization is not indicative of the nation-wide needs of spinal [illegible] injured veterans.

I have employed the example of the VA's SCI program because it is the one with which PVA is most familiar, and the inappropriate placement of DOD facilities in Chicago and New Orleans are examples which are widely known. Likewise, the combination of fiscal restraints and political selfishness has prevented the construction of an urgently needed VA hospital in Baltimore, Maryland.

In these times of fiscal restraints, it is more important than ever before that VA and DOD facilities be located where they are needed by their beneficiaries, whether those persons are on active military duty or are veterans. In determining possible sharing agreements to exist between the VA and the Department of Defense, or other federal agencies, it is not enough to look at the mere aggregate number of hospital beds each system has. Rather, it is imperative to examine the accessibility of those beds to the intended users of them. Furthermore, any new construction projects within these systems should be based on clear analysis of accurate placement of them, to give optimal service to the users and to the taxpaying public which provides for such services and facilities. This long-term planning has not gone into the placement of VA and DOD facilities in the past, and this has given rise to the problems noted by Senator Percy and Senator Murkowski.

PVA trusts that a sharing agreement plan between the Department of Defense and the Veterans Administration would result in this needed planning. Even without such an agreement, we hope that Congress will more closely examine the placement of VA facilities and will work to ensure the continuation of existing ones and the construction of new ones upon the basis of their need.

Thank you for your time and consideration, and, on behalf of the members of Paralyzed Veterans of America, I appreciate the very fruitful Committee hearing led by Senator Murkowski.

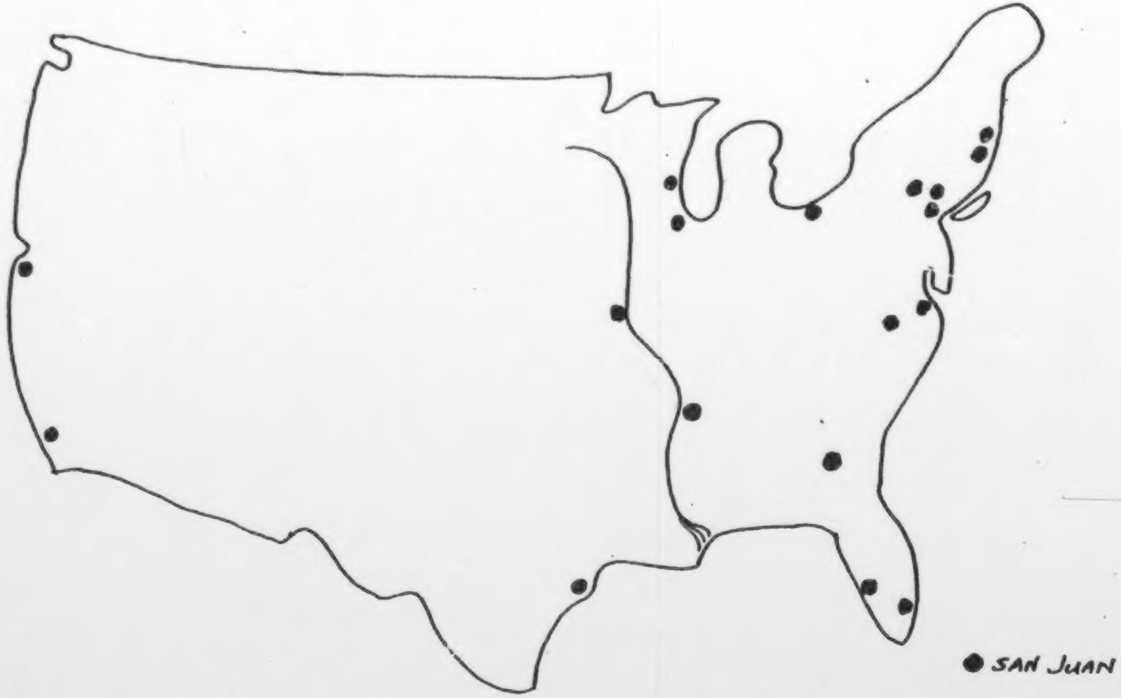
Sincerely yours,

R. Jack Powell
Executive Director

Attachment

cc: All Members of the Senate Committee on Veterans Affairs

GEOGRAPHIC DISTRIBUTION OF VA SCI CENTERS



APPENDIX A

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

The Congress Should Mandate Formation Of A Military-VA-Civilian Contingency Hospital System

The Department of Defense (DOD) is developing a civilian-military contingency hopital system for treating returning battlefield casualties because it has insufficient resources of its own. However, several issues and unanswered questions regarding DOD's implementation plans need immediate attention.

The most important issue, in GAO's opinion, is the extent of support the Veterans Administration (VA) will provide DOD. DOD plans considered limited VA assistance. VA cannot fully support DOD without modifications to VA's current legislative authority and responsibilities. Therefore, GAO recommends that the Congress enact needed legislation.

GAO also recommends the development of plans using available Federal and civilian medical resources to treat battefield casualties. Such plans should include coordination of civilian resources with both DOD and VA facilities.

UNITED STATES GENERAL ACCOUNTING OFFICE

HRD-80-76
JUNE 26, 1980

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-196409

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the need for developing a contingency hospital system consisting of Department of Defense, Veterans Administration, and civilian medical resources. The report's primary emphasis is our belief that the Veterans Administration's role should be greater than currently planned by the Department.

We performed this review at the request of Representative Robin Beard.

We are sending copies of the report to the Secretary of Defense; the Administrator of Veterans Affairs; the Director, Office of Management and Budget; the Director of the Federal Emergency Management Agency; and other interested parties.

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

THE CONGRESS SHOULD MANDATE FORMATION OF A MILITARY-VA-CIVILIAN CONTINGENCY HOSPITAL SYSTEM

DIGEST

The extent of support the Veterans Administration (VA) will provide the Department of Defense (DOD) in treating returning battlefield casualties is the most important issue in developing a civilian-military contingency hospital system for medical treatment of wartime casualties.

DOD PLANNING TO USE CIVILIAN HOSPITALS IN WARTIME

DOD has looked primarily to civilian medical resources to meet anticipated shortfalls should the United States become involved in war. Only recently has specific consideration been given to VA's medical capability. DOD officials said that civilian resources would still be needed to treat battlefield casualties, even if DOD and VA resources were fully used for that purpose.

DOD planned to begin implementing a civilian-military contingency hospital system in October 1979. GAO recommended that implementation be suspended because of several unresolved or unexplored issues. (See app. I.) DOD did not agree with GAO's recommendation, and felt the system should proceed. Unresolved issues would be addressed during implementation. (See p. 4 and app. II.)

DOD recently revised several aspects of its original system. Major changes appear to be (1) elimination of a new, possibly duplicative administrative structure as originally proposed and (2) reliance on the military services for patient administration responsibilities.

GAO agrees with these revisions. However, more issues and uncertainties concerning

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the extent of VA participation, and civilian bed and staff availability remain to be resolved. (See pp. 9, 12, and 15.)

UNCERTAINTIES REMAIN CONCERNING DOD'S PLANS TO USE NONMILITARY HOSPITALS

DOD's original plan focused on identifying excess beds, which GAO believed would be a limited indicator of bed capacity usable on short notice. (See p. 10.) DOD's plans also assumed that medical staff would be available, but lacked specific information about how physician and support staff would be obtained. (See p. 14.)

DOD's revised plans are still unclear about how civilian beds and staff would be made available. The military services will have discretion over determining how to secure civilian resources. GAO believes available beds and staff should be identified assuming (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. (See p. 15.)

OTHER ISSUES TO BE RESOLVED BEFORE USING CIVILIAN HOSPITALS

DOD needs to further address, with the military services and other organizations, issues concerning regulation of patient transfers (see p. 19) and ground transportation (see p. 20). Issues also remain regarding civilian physician and hospital reimbursement and liability (see p. 24) and coordination with the Federal Emergency Management Agency, the Department of Health and Human Services, 1/ and other agencies having wartime

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1/On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

planning responsibilities. (See p. 25.) GAO believes that failure to resolve these issues could limit implementation of the planned system.

VA AS A POTENTIAL WARTIME MEDICAL RESOURCE

DOD and VA have recently been discussing possible wartime coordination of medical resources, but some questions about VA's participation remain. DOD plans for VA to care for battlefield casualties not expected to return to duty--that is, service-connected veterans. However, VA's mission is to care for such veterans; therefore, such a plan involves no real change from VA's current primary responsibilities. (See p. 13.)

GAO believes that VA should be much more involved in planning and caring for battlefield casualties than it would be in caring only for those who will not return to duty. Just how much VA can participate is questionable. DOD has not told VA what its needs are, nor has VA told DOD what its capabilities are. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support casualty treatment in the United States, unless it was given that mission in other than a declared national emergency. (See pp. 12 to 15.)

In GAO's opinion, the Nation should prepare for a possible conflict by planning to appropriately use Federal medical resources before calling on civilian resources. Moreover, GAO believes that a strong peacetime medical resources sharing program, such as that which it recommended in its June 1978 report, could provide a more effective relationship between VA and DOD that could prove invaluable in war. (See pp. 15 and 31.)

RECOMMENDATIONS TO THE CONGRESS

GAO recommends that the Congress enact legislation which provides that both DOD and VA fully participate in Federal medical planning for and care of returning wartime casualties. Such legislation should:

--Give VA the mission of providing direct medical support to DOD for treating battlefield casualties.

--Place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.

--Remove numerous obstacles to interagency sharing, as GAO previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system. (See p. 31.)

RECOMMENDATIONS TO DOD AND VA

GAO recommends that the Secretary of Defense and the Administrator of Veterans Affairs jointly:

--Develop and establish the framework for a military-VA-civilian contingency hospital system.

--Analyze DOD's and VA's medical care resources to determine the Federal patient treatment capability on a time-phased basis.

--Identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. (See pp. 31 and 32.)

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

The Secretary should:

--Compare the medical care requirements calculated under various wartime scenarios with available Federal medical resources to determine how much and what type of civilian medical care capability would be needed to augment Federal capability.

--Determine the optimal number and placement of U.S. aeromedical staging facilities with emphasis on locations near concentrations of military and VA medical resources.

--In concert with other agencies having contingency planning responsibilities, assume overall coordinating responsibility for plans jointly developed by DOD and VA using Federal medical resources and necessary civilian medical capability under the military-VA-civilian contingency hospital system. (See p. 32.)

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

The Administrator should:

--Provide estimates to DOD concerning VA's potential facility and staffing capabilities to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty. These estimates should be developed through the joint DOD-VA planning effort to establish a military-VA-civilian contingency hospital system.

--Ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties. (See pp. 32 and 33.)

AGENCY COMMENTS AND GAO'S EVALUATION

DOD, VA, and the Federal Emergency Management Agency indicated their concerns about how the full implementation of the recommendations would affect their current plans and operations. GAO believes the comments provide further evidence that congressional guidance is needed to establish an effective military-VA-civilian contingency hospital system.

DOD stated that actions necessary to carry out the recommendations to the Secretary of Defense had already been initiated. It noted that active dialogue with VA is now in progress for wartime planning.

Notwithstanding the dialogue, GAO believes that DOD is proceeding to implement only a slightly modified version of its original plan. GAO does not agree with this approach. (See pp. 33 to 35.)

VA stated its concern regarding possible misinterpretations of several recommendations. GAO recognized these concerns and clarified the recommendations. (See pp. 35 to 36.)

The Federal Emergency Management Agency was concerned that it and the Department of Health and Human Services had not been sufficiently included in DOD's planning and development of the contingency system. (See pp. 36 and 37.)

Contents

Page

DIGEST i

CHAPTER

1 INTRODUCTION 1
- DOD wartime medical planning to use civilian hospitals 2
- Scope of review 5

2 UNCERTAINTIES REMAIN CONCERNING DOD'S PLANS TO USE NONMILITARY HOSPITALS TO MEET WARTIME NEEDS 8
- Bed capability 9
- VA's medical capability not fully developed as a potential wartime medical resource 12
- Potential availability of staff in nonmilitary medical facilities 15

3 OTHER ISSUES NEEDING RAPID RESOLUTION AS DOD PLANS FOR USE OF CIVILIAN HOSPITALS 19
- Regulating patient transfers from overseas to the United States 19
- Patient transfers from airfields to hospitals 20
- Patient administration 24
- Reimbursement and liability 24
- Coordination with other agencies 25

4 CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND OUR EVALUATION 28
- Conclusions 28
- Recommendations to the Congress 31
- Recommendations to DOD and VA 31
- Recommendations to the Secretary of Defense 32
- Recommendations to the Administrator of Veterans Affairs 32
- Agency comments and our evaluation 33

Page

APPENDIX

I GAO's October 25, 1979, report to the Secretary of Defense 38

II DOD's reply to GAO's October 25, 1979, report 42

III Letter dated May 14, 1980, from DOD 46

IV Letter dated May 13, 1980, from VA 47

V Letter dated May 2, 1980, from FEMA 50

ABBREVIATIONS

AHA	American Hospital Association
ASF	aeromedical staging facility
ASMRO	Armed Services Medical Regulating Office
CMCHS	Civilian-Military Contingency Hospital System
DOD	Department of Defense
EMS	Emergency Medical Services
FEMA	Federal Emergency Management Agency
GAO	General Accounting Office
HHS	Department of Health and Human Services
JMRO	Joint Medical Regulating Office
MAC	Military Airlift Command
MMLO	Military Medical Liaison Office
PHS	Public Health Service
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

In response to a May 1, 1979, request from Congressman Robin Beard, we reviewed the Department of Defense (DOD) plans to use nonmilitary hospitals to treat battlefield casualties in the event of war or conflict. During this effort, we identified several important issues relating to those plans which need immediate attention. Accordingly, as agreed with the Congressman's office, although we did not perform a detailed, comprehensive review of these issues, this report discusses the issues so that they may be considered during proposed congressional hearings and DOD's continuing preparedness planning process.

DOD's health care system is comprised primarily of the direct care systems of the Army, Navy, and Air Force. 1/ These systems are to provide medical care to support the U.S. military forces. For example, the Army Surgeon General stated during 1978 congressional hearings that the Army Medical Department's objectives include:

--Maintaining physically and mentally fit soldiers and trained health staff to support Army combat, contingency, and mobilization plans.

--Providing care and treatment capabilities for combat casualties in a theater of operations and in the United States.

The size of DOD's direct care medical operations worldwide is shown in the following table.

	Number of			
	Hospitals		Clinics	
Military service	U.S.	Other	U.S.	Other
Army	36	12	75	54
Navy	23	8	136	34
Air Force	65	16	20	20
Total	124	36	231	108

1/In addition to DOD's direct medical care system, dependents of active duty members, retirees and their dependents, and dependents of deceased members may obtain medical care in the civilian sector under the Civilian Health and Medical Program of the Uniformed Services.

The medical facilities in the direct care system range from small clinics with limited medical capabilities to large medical centers with extensive medical specialty capabilities and medical teaching programs. In fiscal year 1978, DOD's total normal bed capacity 1/ was about 35,000. However, fewer than 20,000 beds were actually set up, staffed, and equipped, and an average of fewer than 16,000 were actually occupied.

To assure patient access to medical care, DOD operates a worldwide aeromedical evacuation organization. The Air Force's Military Airlift Command (MAC) operates various types of aircraft for aeromedical evacuation missions from overseas to the United States and throughout this country. During peacetime, the Air Force uses the same system that would be expanded and used during wartime.

The Veterans Administration (VA) hospital system is much larger than DOD's. In November 1979, VA operated 172 hospitals containing over 85,000 beds.

DOD WARTIME MEDICAL PLANNING TO USE CIVILIAN HOSPITALS

DOD has historically relied extensively on its own medical resources to care for sick and wounded personnel evacuated from overseas conflicts. Past conflicts generated a need for large quantities and various types and levels of medical services to care for military personnel. However, in the past, sufficient time was available to build up medical support units and other medical care system elements to provide treatment to returning casualties.

Current wartime planning scenarios discuss U.S. involvement in short but intense conventional warfare. Under such scenarios, adequate time may not be available for a gradual and orderly buildup of medical care capability in the theater of operations or in the United States. In a short, intense conflict, many casualties would be incurred quickly. This situation would require that much of the military's total active duty medical personnel resources be committed in the theater of operations to handle early life-saving, patient

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1/Normal bed capacity refers to the space available in existing hospitals where beds could be set up. However, DOD does not have the beds, staff, or equipment needed to make the space usable for patient treatment.

stabilization, and definitive care requirements. The resources remaining in the United States would be quickly strained until they could be augmented by reserve personnel, draftees, and others.

DOD officials told us that current war planning scenarios result in casualty estimates so large that non-Federal civilian medical resources would be needed even if both DOD and VA capabilities were fully used to treat battlefield casualties. Studies have shown that most casualties would have to be treated in non-DOD facilities.

Health program planning guidance directs DOD to look to civilian staff and nondefense facilities for capability to meet anticipated wartime requirements. The guidance recognizes that there would be military medical personnel shortages resulting from a major conflict, and that the ability to quickly augment military facilities with reserve personnel or draftees would be limited. To date, most of DOD's planning efforts have concentrated on civilian resources. Only recently has any specific consideration been given to other Federal capability, such as that provided by VA.

DOD and other planning efforts regarding the use of civilian medical resources include:

--A 1978 DOD study concerning DOD's wartime reliance on civilian sector health care resources.

--A 1979 report by Maximus, Inc., a private contractor, entitled "Study of the Problems Associated with Reliance on Civilian Medical Manpower and Non-DOD Facilities During Periods of National Emergency, Mobilization, and War."

--Two Contingency Support Plans (OPLANS 9550) prepared at two Air Force hospitals. They are not Air Force policy and represent plans only for the facilities where they were developed.

The Maximus report, completed in March 1979, addressed the potential for using civilian hospitals to augment DOD medical resources in a major conflict. It is the most comprehensive effort that DOD has supported or undertaken in this area. The report recommended that DOD establish a Civilian-Military Contingency Hospital System (CMCHS) to coordinate DOD's use of wartime medical resources. CMCHS included setting up the following organizations to facilitate obtaining medical care from the civilian sector:

--A DOD-level office--the Office of Civilian-Military Contingency Hospital System--to organize, implement, and oversee a system of DOD-linked civilian hospitals.

--A series of Military Medical Liaison Offices (MMLOs) to interface with participating local civilian hospitals. The MMLOs would be located in major metropolitan areas where adequate civilian medical capability had been identified. The Maximus report identified 41 such areas.

Maximus also recommended that CMCHS be implemented by establishing formal contracts and agreements with civilian hospitals in the 41 areas. Under the Maximus concept, DOD would obtain access to about 40,000 beds for wartime purposes.

On the basis of the Maximus report, the Assistant Secretary of Defense for Health Affairs circulated a draft directive establishing CMCHS to the military services for comment. We understood that DOD originally planned to begin CMCHS implementation in October 1979.

On October 25, 1979, we recommended that implementation of CMCHS be suspended. (See app. I.) In our opinion, many fundamental issues for developing a contingency medical system with the civilian sector were either unresolved or unexplored. Included were issues concerning (1) whether excess civilian beds and medical staff were in fact available and (2) a lack of adequate coordination with the Selective Service System, the Federal Emergency Management Agency (FEMA), and the Department of Health and Human Services (HHS). 1/ These organizations have responsibilities for preparedness programs involving the Nation's medical resources during wartime. Also, DOD appeared to be proceeding to implement CMCHS without an accurate picture of what total Federal medical capability could be obtained.

DOD did not agree with our recommendation that implementation of CMCHS be suspended. In a December 10, 1979, response to our report, DOD stated that CMCHS should proceed and that the unresolved issues would be addressed during the system's implementation. (See app. II.)

1/On May 4, 1980, a separate Department of Education commenced operating. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

In January 1980, DOD circulated another CMCHS draft program directive to the services for comment. DOD's new draft directive is a continuation of its CMCHS planning efforts. DOD has revised some of the original concepts proposed by Maximus and included in the earlier draft directive. For example, DOD officials told us that proposed administrative structures such as the MMLOs have been dropped. Administrative functions will now be performed by the military services through DOD hospitals, rather than by the MMLOs.

Implementation of CMCHS is now beginning. The new CMCHS Director joined DOD in early March 1980, and the Deputy Director arrived in late April.

Under CMCHS as now being implemented, civilian hospitals in the United States will be linked by formal agreement to the DOD health care system. DOD has no current estimate of the number of beds that will ultimately be involved in the program. VA hospitals, while not a formal part of the CMCHS administrative structure, will also help DOD treat returning wartime casualties, according to DOD officials.

Another Maximus report concerning VA capabilities was issued on December 31, 1979. This report recommended that DOD and VA continue their efforts to develop and maintain a working contingency system which would enhance wartime preparedness. The report recommended, in part, that DOD intensify its planning efforts with VA to:

--Develop specific contingency plans.

--Draft and sponsor legislative language to permit VA hospitals to give higher priority to care of active duty patients during wartime.

Although the above recommendations, if implemented, would enhance VA's role in any proposed contingency hospital system, uncertainties regarding the extent of VA participation and civilian bed and staff availability remain to be resolved.

SCOPE OF REVIEW

We made our review at the headquarters offices and selected health care facilities of DOD and VA and at several civilian health organizations. Our general objective was to evaluate DOD's and the military services' plans and efforts to involve the civilian sector and other Federal capability in providing medical care to war casualties.

Although we visited many locations and spoke with numerous Federal and civilian officials, we did not perform a detailed review or evaluation of the issues discussed in this report. We concentrated on assessing whether DOD had sufficiently explored these issues, either itself or through contractor studies, to be able to implement an effective system for using nonmilitary resources in wartime. We limited our fieldwork in order to give the Congress timely information on the unresolved issues which may be discussed during hearings proposed by the Chairmen of the Subcommittees on Military Personnel and Military Compensation of the House Armed Services Committee on DOD's wartime medical posture.

To identify military medical plans and procedures, we met with officials of DOD's Office of Assistant Secretary of Defense for Health Affairs; Office of Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics; Offices of the Surgeons General of the Army, Navy, and Air Force; and Armed Services Medical Regulating Office (ASMRO). Our work with these officials was conducted at their headquarters in the Washington, D.C., area. We also visited the Army's Health Services Command in San Antonio, Texas.

We met with VA's Chief Medical Director to discuss support for DOD during wartime. We also visited representatives of the American Hospital Association (AHA); Maximus, Inc.; FEMA; and HHS.

At the field level, we discussed with Federal and civilian hospital managers their capabilities to support wartime efforts. We visited MAC headquarters at Scott Air Force Base, Illinois, to discuss aeromedical evacuation plans and procedures. We visited 3 of 10 Air Force bases which have aeromedical staging facilities (ASFs) designed to receive returning war casualties. We also met with representatives of civilian emergency medical services units to discuss their patient transportation capabilities, and health systems agency 1/ officials to discuss excess bed capability.

The following Federal facilities and civilian organizations were included in our review:

1/Health systems agencies are the primary health planning organizations for specified geographic areas of the country. They are responsible for obtaining information on medical care resources in the local areas.

Washington, D.C., area

Malcolm Grow USAF Medical Center, Andrews Air Force Base

Scott Air Force Base, Illinois

USAF Medical Center, Scott

San Antonio, Texas, area

Brooke Army Medical Center
Wilford Hall USAF Medical Center
Audie L. Murphy Memorial Veterans Administration Hospital
Bexar County Emergency Medical Service
Camino Real Health Systems Agency

Los Angeles, California, area

USAF Clinic, Norton Air Force Base
Air Force Regional Hospital, March Air Force Base
Naval Regional Medical Center, Long Beach
Veterans Administration Hospital, Long Beach
Veterans Administration Hospital, Loma Linda
Inland Counties Emergency Medical Authority
Inland Counties Health Systems Agency

San Diego, California, area

Naval Regional Medical Center, San Diego

CHAPTER 2

UNCERTAINTIES REMAIN CONCERNING DOD'S PLANS TO USE NONMILITARY HOSPITALS TO MEET WARTIME NEEDS

DOD's major studies and efforts completed to date leave several unanswered questions concerning its ability to work directly with civilian hospitals to secure wartime medical care capability. Also, more needs to be done to get the Federal sector--primarily DOD and VA [1]--working together as a team, planning to maximize use of Federal medical capabilities in time of war or conflict.

We identified several problems and uncertainties with DOD's original plan to use civilian medical capabilities. DOD's civilian sector efforts focused on identifying excess beds, which we believe may be a limited indicator of bed capacity that would actually be usable on short notice. DOD plans also assumed that medical staff would be available, but lacked specific information about how physician and support staff would be obtained.

DOD's revised plans are unclear about how civilian beds and staff would be identified and under what arrangements they would be made available. Moreover, although DOD and VA have begun to discuss coordinating resource use during wartime, questions remain about the extent of VA's involvement in this effort. Our work suggests that an excellent opportunity exists to develop an effective and available contingency medical system within the Federal community by giving VA responsibility for assisting DOD in developing plans for and providing care to wartime casualties. The civilian sector could then be relied on for any additional capability deemed necessary.

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[1] A Public Health Service (PHS) official told us that several meetings were held among PHS, DOD, and Maximus officials to discuss the possible use of PHS resources in wartime. The officials agreed that, because of limited resources, DOD should not rely on PHS for wartime medical assistance.

BED CAPABILITY

Although DOD has sponsored two efforts to assess the availability of civilian medical care, it still does not have an accurate picture of the number and types of beds it could obtain either throughout the United States or in specific geographic areas. The reason is that both efforts focused on estimates or reports of excess civilian hospital beds without verification of actual bed availability. Also, only recently has the availability of other Federal medical capabilities been addressed.

DOD's civilian sector survey provided inadequate data

In 1978, DOD directed the military services to conduct a survey around each military medical facility to identify civilian medical resources which could be relied on during mobilization. According to military service reports to the Assistant Secretary of Defense for Health Affairs, the consolidated survey results were inadequate for use in planning wartime operations. We reviewed the surveys conducted at three military medical installations and found that they used substantially different methodologies.

In San Antonio, for example, Brooke Army Medical Center and the Air Force's Wilford Hall Medical Center reported that 14 civilian hospitals in San Antonio could care for 1,200 casualties on a short-term or no-notice basis. The civilian capability was based on reported excess bed statistics for non-Federal hospitals compiled by a local government agency.

The Naval Regional Medical Center, Long Beach, also reported local capabilities in terms of excess hospital beds. Long Beach calculated the number of beds within 20 miles of the hospital, using statistics in the AHA Guide to Health Care Institutions. Fifteen percent of the hospital beds identified were then reported as available for use during mobilization.

We found that the Naval Regional Medical Center, San Diego, sent letters to area hospitals, asking how many patients above normal patient loads might be admitted on short notice during mobilization. Responses from 27 hospitals identified 630 medical/surgical, 104 psychiatric, and 77 other beds as available within 48 hours after notification of mobilization.

The San Diego survey results indicate that some of the 1978 survey data were reasonably good, but the services' reports to DOD noted that the overall data were severely limited. In addition, the Navy recommended that a more extensive and methodical study of civilian resource availability be done.

DOD's original plan to use civilian beds

Maximus, Inc., issued its report on civilian medical resource use in wartime on March 15, 1979. However, the Maximus data, like the 1978 DOD study, had some serious limitations.

Excess hospital beds were the basis on which Maximus assessed civilian capability to support military medical readiness. The Maximus report discussed the type, size, and distribution of hospitals in the United States and offered a number of alternatives for defining the number of beds that might be available to DOD.

Ultimately, Maximus estimated the number of beds available in 41 selected metropolitan areas using essentially the same approach as that used by the Long Beach Naval Hospital. That is, Maximus calculated available excess beds by taking 15 percent of selected civilian hospital beds in the area reported as having been set up and staffed. However, only six hospitals located in 2 of the 41 metropolitan areas were visited. Therefore, little was known about whether those beds were actually available or whether there would be equipment and staff to operate them.

Excess hospital beds, as calculated by Maximus, may be a limited indicator of actual capability because the "excess" beds may not be adequately staffed. According to HSA officials, excess beds are a meaningful measure of the civilian sector's capability to respond to an immediate need for medical care *if* the beds are actually set up and staffed. However, because many hospitals have reduced nursing staffs to core groups, which are supplemented by temporary nurses, beds reported as set up and staffed may not be available on a full-time basis.

Administrators at two San Antonio civilian hospitals also told us that some beds are classified as set up and staffed when in fact they are not staffed. At one hospital, the administrator stated that unstaffed beds could be made available only when staff could be provided from the hospital's school of nursing. At another hospital, we were told that the core nursing staff could handle all the beds reported as set up and staffed, but only for less than 1 week. Additional staff would be needed for longer periods.

In addition, the original CMCHS concept was to use only a small portion of a civilian hospital's facilities and medical staff, and assumed that normal civilian health care delivery would not be affected. Maximus made this assumption in its study, even though large numbers of casualties were expected, and all military and other Federal health facilities were expected to be severely taxed.

In our opinion, this assumption was unrealistic and limited the potential effectiveness of a civilian-military linked medical system. It was unrealistic because an intense war that would generate great numbers of casualties could not help but disrupt the normal functions of many of the Nation's activities. It would limit the effectiveness of a civilian-military system because casualties would have to be scattered throughout a large number of civilian hospitals. Transportation and administrative burdens would increase with each hospital added to the system, making control over patients more difficult.

Some DOD hospitals have attempted to determine how they would deal with the influx of casualties from a war or conflict. For example, Malcolm Grow and Scott Air Force hospitals expect to accommodate incoming casualties by divesting patients who could be transferred to other smaller military, VA, or civilian hospitals. For patients requiring transfers to other hospitals, such facilities are identified in each hospital's Contingency Support Plan, OPLAN 9550. Malcolm Grow and Scott officials surveyed nearby hospitals to determine their ability to receive various categories of wartime patients. Both hospitals also developed plans to expand and reconfigure their facilities to meet their medical missions during the wartime surge period. The hospitals' plans were based on the assumption that DOD funds and staffing would be provided to support such expansions.

DOD's revised plans remain unclear

DOD issued a revised draft directive concerning the CMCHS program on January 7, 1980. The directive defines CMCHS as civilian hospitals linked by formal agreements to the DOD health care system through a Federal hospital in the same geographic area. Linkages will be accomplished either through the use of contracts or letters of agreement.

DOD's revised plan does not include guidance on how civilian hospital resources should be obtained (e.g., through excess beds or some other arrangement). DOD officials told us that the specifics would be up to officials in the military services, who may or may not use concepts discussed in the Maximus study.

While many aspects of CMCHS remain unclear, DOD officials told us that the need for CMCHS clearly exists. They said that DOD planning scenarios estimate large numbers of casualties being returned to the United States. The casualty estimates are constantly being revised based on latest intelligence and other data. DOD officials said that, based on current estimates, however, both the DOD and VA systems would become saturated and that some civilian medical resources would be needed to treat battlefield casualties. Studies have shown that most casualties would have to be treated in non-DOD facilities.

VA'S MEDICAL CAPABILITY NOT FULLY DEVELOPED AS A POTENTIAL WARTIME MEDICAL RESOURCE

As discussed on page 2, as of November 1979, VA operated 172 hospitals containing over 85,000 beds. VA also has affiliation agreements with many civilian medical schools and hospitals which it could, conceivably, use to enhance its ability to provide care to battlefield casualties.

Although DOD and VA have begun to coordinate on possible wartime relationships, questions remain about the extent of VA's involvement and legislative and/or procedural changes needed to increase that involvement.

In connection with the Maximus contract to assess VA capability, DOD requested information on possible VA assistance during wartime. In a September 4, 1979, letter to VA, the Acting Assistant Secretary of Defense for Health Affairs asked for VA capability available to DOD in terms of hospital location, numbers of beds, types of active duty patients that can be accommodated, and time phasing of bed availability.

VA did not provide the data DOD requested. However, in an October 19 letter to DOD, the Administrator of Veterans Affairs stated that more contingency planning is necessary, and assigned the Chief Medical Director and his staff to work with DOD representatives to that end.

The Administrator also raised questions about the support VA could actually provide DOD under existing legislative authorities. For example, he stated that, although authority exists for some interagency sharing of resources between VA and DOD, VA's basic statutory mission ensures treatment availability to VA beneficiaries, with preference to those having service-connected disabilities. He also stated that, in light of this statutory constraint, VA foresees some difficulty in meeting all of the contingency needs being considered by DOD. The Administrator concluded that some legislative modifications will be necessary, if it is decided that VA's mission should be expanded to include contingency support to DOD during wartime conditions, other than a declared national emergency.

DOD officials told us that VA hospitals would be considered for use in treating returning battlefield casualties before civilian hospitals. VA would be expected to provide care to casualties who would not be returned to duty. These casualties would become VA's responsibility since they would have service-connected conditions and would fall into VA's highest priority treatment category. The officials were also interested in sending patients to VA who would return to duty. They were unsure, however, whether VA statutes or regulations would prevent this arrangement.

While treatment of battlefield casualties discharged from the service has historically been VA's responsibility, neither DOD nor VA has any estimate of how many of these casualties would be flowing from DOD to VA under existing scenarios. DOD has just recently begun to develop such estimates. Until these estimates are developed, no one will know what capability, if any, VA might have to treat battlefield casualties who are expected to return to duty.

VA's Chief Medical Director told us that many of the country's major population centers have large concentrations of both DOD and VA medical capability that could be used to treat battlefield casualties. He indicated, however, that VA's existing authorizing legislation limits the assistance VA can provide to DOD in a contingency. Modifications in VA's legislation would be necessary to give casualties expected to return to duty a sufficiently high priority for VA to treat substantial numbers of such casualties in its facilities. These modifications would include placing battlefield casualties above veterans with non-service-connected, nonemergency conditions, in VA's priorities for care.

VA hospital directors we interviewed said they could make a substantial number of beds available for wartime casualties by (1) transferring and discharging patients when appropriate and (2) limiting admissions to life-threatening emergencies during the war surge period. The directors believe that using the VA hospital system would be a logical way to extend the military's capability to treat wartime casualties. However, they said that it would be necessary to change VA's priorities for providing medical care during wartime in order to follow this approach. In their opinion, a policy to change eligibility priorities to place battlefield casualties above veterans with non-service-connected conditions would be required before VA could assist DOD in the above manner.

The VA hospital directors also said they could determine how many patients could be treated within existing capabilities if VA knew how many patients would arrive within a defined time period, what types of injuries they would have, and where to expect them. In addition, the capability to handle casualties could be expanded by (1) discharging patients at the earliest possible time, (2) waiving space per patient requirements, (3) reducing research and teaching programs, (4) eliminating or reducing special treatment programs and specialties, (5) delaying admissions for nonemergency conditions, and (6) increasing staffing by using existing affiliation agreements with medical school hospitals and by transferring staff from other VA hospitals. The directors emphasized again, however, that eligibility priorities would need to be changed before this assistance could be provided.

Observations

Although DOD plans to use VA in treating battlefield casualties, VA assistance may be limited due to statutory restrictions on its ability to accept active duty military patients. We believe that DOD and VA, with the legislative modifications discussed by VA officials, can provide the basis for an efficient and effective contingency hospital system.

There are currently no estimates of the numbers of casualties not expected to return to active duty. As a result, the potential capability of VA to treat that category as well as those expected to return to active duty is unknown. However, it seems logical that VA be given the authority to treat any casualties which the VA system might be able to treat. DOD and VA should have the flexibility to allow the use of Federal medical capabilities to their best advantage.

DOD's original CMCHS plan calculated excess beds as a measure of civilian bed availability to support wartime needs. We believe this is a limited indicator of bed availability that would be usable on short notice. Federal and civilian hospitals should be asked to identify capability that could be provided assuming patients are discharged early and nonemergency admissions are restricted during the war surge period. These actions would free beds and staff, which could then be available to treat battlefield casualties.

In our report, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978), we stated that the military and VA medical systems need to work more closely together and share their medical resources. We recommended that the Congress enact legislation to encourage increased interagency sharing of Federal medical resources and remove numerous obstacles we identified as inhibiting such sharing. Such legislation has recently been introduced but not yet acted upon. We believe that an active Federal medical resource sharing program could provide the foundation for building effective working relationships between VA and DOD during peacetime that could be invaluable in war.

POTENTIAL AVAILABILITY OF STAFF IN NONMILITARY MEDICAL FACILITIES

DOD's original study, conducted by Maximus, included little information about the potential availability of medical staff in civilian hospitals that might ultimately participate in CMCHS. Rather, it concluded that acquiring the necessary medical staff would be the responsibility of the participating hospitals.

Likewise, DOD's revised plans for using civilian hospitals do not address the issue of staff availability during wartime. In addition, as with bed capability, the feasibility of obtaining VA medical and support staff has not been fully explored. However, as mentioned, DOD and VA are working toward a wartime contingency arrangement.

The issue of civilian hospital staff availability

The original CMCHS, as proposed by Maximus, was tested in 1978 as part of "Nifty Nugget," a military exercise of U.S. mobilization capability for a limited war. Physician participation was not directly measured in this exercise. Rather, participating hospital administrators--from eight hospitals in two metropolitan areas--were asked to advise physicians of the test and its importance. From the test results, Maximus reported that physicians would be available, if for no other reasons than their Hippocratic oath and their patriotism.

Maximus discussed reserve callup and the physician draft only in general terms and in the context of the "Nifty Nugget" exercise. Most hospital administrators believed that, even if reserves were called up and the physician draft reinstituted, they could call in physicians from surrounding and outlying areas. Thus, Maximus' initial assessment was that sufficient civilian physician staff would be available during the early surge of CMCHS activation and that physicians would be cooperative.

In its conclusions, the Maximus report identified a number of tasks for the civilian medical community that would participate in CMCHS and raised a number of unresolved issues. Specifically, the report stated that:

--Civilian hospital administrators should be tasked to obtain physicians for patients admitted under CMCHS. At a minimum, the hospitals should maintain a list of physicians as part of their emergency preparedness plans. A hospital without a list of physicians available for emergency duty should not be permitted to participate in the system.

--Hospital administrators should, as a part of their plans for CMCHS, develop procedures for coping with nonavailability of physicians and other critical staff.

--The roles and relationships of active duty, reserve forces, and CMCHS physicians should be examined to determine where the physicians or unit could have the greatest value. Choices would have to be made among drafting physicians, deferring physicians at CMCHS hospitals, or delaying CMCHS physicians' induction for some specified period of time, say 180 days, to allow them to serve CMCHS during the initial stages of a conflict.

During our discussions with DOD and VA physicians and hospital administrators, we obtained their views about Maximus' idea that civilian physicians would be likely to cooperate under a program such as CMCHS. They believed that current civilian physician-hospital relationships could pose a problem for such a program. In this regard, they said that, unlike structured systems, such as DOD and VA, civilian hospital administrators do not have an effective mechanism for influencing doctors to practice at any one hospital. For example, in large communities most physicians have admitting privileges and practice medicine at more than one hospital. The physicians would be free to leave a hospital if they believed the conditions associated with admitting privileges were not suitable. This situation would, in their opinion, diminish the ability of an administrator of a hospital participating in CMCHS to effectively deal with physician availability during wartime.

DOD officials told us that under the revised CMCHS program the issue of staff availability is still the responsibility of civilian hospital administrators.

VA's hospital system could potentially provide additional wartime staffing

VA administrative and clerical employees could be made available to assist DOD with casualties, according to VA officials. The administrative and clerical employees who normally handle VA patient paperwork could handle that associated with battlefield casualties. We were told that the job requirements for VA medical administrative and clerical positions are probably very similar to those of the military services. Also, the military and VA use standardized medical record forms, laboratory slips, and clinical history sheets. If treating military casualties increases workload, the administrative staff could be augmented either from areas within the hospital or from other sources, such as nearby VA facilities or through new hires.

VA officials also told us that physicians, nurses, and technicians could be detailed from one VA hospital to another if additional staffing was needed to care for casualties. For example, if casualties were being treated at Loma Linda (about 4 miles from the Norton Air Force Base ASF), staff from other VA hospitals could be detailed there under existing legislative authority.

However, VA officials stated that certain problems could arise. For example, physicians might leave VA if they were detailed, and housing and transportation might be needed if the location was not close to the employees' home.

On the other hand, VA's Chief Medical Director told us that DOD's use of VA's medical resources for contingency purposes could allow DOD to have immediate access to civilian medical resources. This would include both beds and staff at VA-affiliated medical schools and hospitals. The extent of availability of such support, however, is unknown at this time.

Observations

Obtaining the necessary medical staff to provide care to wartime casualties is an area where much has been assumed and little specific information has been developed. In the original CMCHS study, Maximus placed the responsibility for obtaining the necessary staff on civilian hospitals, as a condition of participation in CMCHS. Evidently, no further plans have been developed under the revised CMCHS program.

DOD does not yet know the full extent of support VA will be able to provide. Our work suggests there are opportunities to use VA medical personnel because they are available, in place and, if necessary, could be moved to provide medical care to wartime casualties if that were made a part of VA's mission or responsibility.

In our recent report to the Congress, "Military Medicine Is in Trouble: Complete Reassessment Needed" (HRD-79-107, Aug. 16, 1979), we stated that, since the draft ended in 1973, the military's direct medical care system has faced a gap between the number of military physicians it needs to provide medical care and the number it actually has. This has seriously impaired the system's ability to efficiently and effectively meet peacetime medical care demands.

It is likely that a short, intense conflict would severely strain an already taxed DOD medical system. VA has the potential to assist DOD by providing a dependable means of treating returning battlefield casualties. The extent of this potential will remain unknown until DOD develops estimates of its requirements for VA's assistance in treating casualties (both those who will not return to active duty and those who will) and VA develops estimates of its capabilities to treat such casualties.

CHAPTER 3

OTHER ISSUES NEEDING RAPID RESOLUTION AS DOD PLANS FOR USE OF CIVILIAN HOSPITALS

DOD needs to resolve several issues--in addition to those relating to civilian bed and staff availability--as it begins to implement a system to use civilian hospitals to treat battlefield casualties. DOD needs to further address issues relating to regulation of patient transfers and transportation with the military services and other organizations. In addition, other unresolved issues regarding (1) civilian physician and hospital reimbursement and liability and (2) coordination with other agencies having wartime planning responsibilities could potentially limit or block effective implementation of a system such as CMCHS.

REGULATING PATIENT TRANSFERS FROM OVERSEAS TO THE UNITED STATES

Military systems exist for regulating patient transfers from overseas to U.S. medical care facilities in both peacetime and wartime. The original CMCHS plan established new organizations and procedures for regulating patient transfers, which left issues unresolved and may have conflicted with current military plans. The revised CMCHS allocates many patient transfer functions to existing military organizations, a plan with which we agree. However, some questions about patient transfer and ground transportation capabilities remain.

The existing patient transfer system

DOD's air evacuation system for moving patients from overseas to U.S. military hospitals is controlled by the ASMRO and MAC. ASMRO determines bed availability, and MAC supplies aircraft to transport the patients.

ASMRO, a joint agency of the Army, Navy, and Air Force, was established to regulate patient transfers to military hospitals in both peacetime and wartime. ASMRO receives reports of beds available in U.S. military hospitals. Peacetime bed reporting is based on about 60 medical categories. In wartime, these beds would be reported by three categories--medical, surgical, and psychiatric.

ASMRO's counterpart overseas is the Joint Medical Regulating Office (JMRO). In wartime, JMRO is responsible for categorizing patient bed requirements into the three categories mentioned above. The wartime plan is for JMRO to tell ASMRO how many and what types of beds are needed. ASMRO would tell JMRO where they are available, and JMRO would tell overseas military hospitals where they could send their patients. The overseas hospitals would decide which patients go to U.S. hospitals with available beds.

The overseas hospitals would also arrange for MAC aeromedical evacuation transportation from overseas to the United States. Patients would then be air evacuated to 1 of 10 ASFs in the United States. Each ASF has capability for holding patients until they are transferred elsewhere for definitive care.

Under DOD's revised CMCHS plans, priority destinations for returning casualties will be (1) the established ASFs, (2) other military airports, and (3) civilian airports. A DOD official stated that there are some disadvantages with using civilian airports. For example, no repair facilities would be available for the MAC aircraft, and civilian airports have no patient holding areas like those at ASFs.

DOD officials also told us that there are not enough ASFs, and more would be needed to accommodate the returning casualties. They also felt that some existing ASFs are in the wrong places. A MAC study is underway to analyze the locations and capabilities of ASFs in the United States.

PATIENT TRANSFERS FROM AIRFIELDS TO HOSPITALS

The original CMCHS included plans to rely on civilian Emergency Medical Services (EMS) units to transport patients from airfields to destination hospitals. However, Maximus recognized that these units have differing capabilities and cannot be relied on without an analysis of those capabilities.

DOD hospitals and ASFs now rely on military transportation organizations, but there are questions about whether these organizations are capable of supporting wartime needs. These questions remain under the revised CMCHS program, but are currently under study.

Civilian transportation capabilities appear questionable

If DOD intends to rely on civilian transportation organizations to help move military patients from airfields to hospitals under the revised CMCHS, some lessons can be learned by examining the original CMCHS concept. The Maximus report acknowledged that the extent to which well-organized EMS units exist throughout the country could not readily be determined. Maximus recommended that DOD determine whether EMS units are organized, available, and capable of transporting arriving military patients before enlisting hospitals in CMCHS. Maximus is proceeding with a separate study to analyze EMS capabilities DOD may need to successfully implement CMCHS.

EMS systems are organized to provide emergency health care services for designated geographic areas. Basic systems are to include areawide coverage by radio-equipped ambulances staffed with technicians capable of providing emergency medical care.

Three EMS units we visited had varying capabilities. In San Antonio, the one EMS unit did not have sufficient capability to support CMCHS operations. The unit had 24 one-litter ambulances stationed at 15 locations throughout the city. According to a unit official, EMS could not, by itself, transport a planeload of litter casualties to local hospitals, without support from area military installations.

In the San Bernardino-Riverside area, California, around the Norton ASF, a regional EMS unit coordinates a four-county operation of 41 separate ambulance companies having a total of 91 ambulances. According to unit officials, transportation for military casualties could be provided. However, a joint military-EMS contingency plan would have to be established, DOD physicians would be needed to evaluate and process patients at the airfield, casualty estimates would be needed to determine whether existing resources are adequate, and the system would have to be tested.

The Los Angeles County EMS unit operates 47 ambulances which could be augmented by about 140 others from civilian organizations in an emergency. Unit officials believe that as many as 100 ambulances could be mobilized, at one time, to move military casualties from airfields to hospitals. According to unit officials, DOD's use of the EMS transportation network would require that an agreement be negotiated with the county board of supervisors, a reimbursement mechanism be established, and a decision be made about operational control--military or civilian--at the airfield.

We agree with the Maximus report that EMS capabilities must be carefully evaluated on an area-by-area basis. It appears that much planning and coordination with civilian officials would be needed before EMS units could be used for transporting casualties.

Military ground transportation to move patients

If DOD plans to use military ground transportation to move patients under the revised CMCHS, an assessment of military capabilities in this area needs to be made.

DOD hospitals and ASFs rely on military transportation capabilities to move patients from airfields to hospitals. Current wartime plans assume that destination military hospitals will provide ground transportation from airfields to hospitals. We visited three military hospitals and found that ground transportation is available, although there are questions about whether capabilities are adequate for wartime needs.

In San Antonio, Brooke Army and Wilford Hall Air Force medical centers operate ambulance buses (ambuses) to provide transportation from airfields to hospitals. Wilford Hall, which also has an ASF, operates two ambuses to transport patients between the flightline at Kelly Air Force Base and the ASF. Hospital officials told us that the purchase of three additional ambuses is planned, because the hospital is authorized five vehicles.

According to ASF officials, Wilford Hall's ambuses will not be used to transport patients to local area hospitals. Instead, destination hospitals, other than Wilford Hall, must provide transportation for patients assigned to them. Brooke Army Medical Center operates two ambuses for this purpose. We do not know what resources exist at other military hospitals served by Wilford Hall's ASF.

We also visited Scott Air Force hospital, where officials told us that a major problem exists in how to transport patients to civilian hospitals. Scott has six old and deteriorating ambuses that could not be relied on, but replacements are expected, so the situation should improve. However, the officials stated that additional resources would be needed during wartime and the civilian EMS unit would not be able to provide much assistance.

In addition, the commander of the clinic at Norton said that transportation is a bottleneck in ASF operations. Norton has three old ambuses and will probably get two more. Even with five ambuses, the commander felt that transportation to local hospitals would be inadequate. He also said that no contacts had been made with civlian EMS units for assistance, and that more planning was needed in the tranportation area.

Current wartime plans assume that destination military hospitals within 100 miles of an ASF will provide ground transportation to move incoming casualties to the hospital. During a 1979 military exercise, questions arose about the capabilities of some military medical facilities to perform this function.

As a result, in April 1979, MAC requested its ASFs to survey all military and VA facilities within 100 miles of each ASF, to determine their transportation capabilities and to identify any deficiencies. MAC did not, however, supply each ASF with information concerning the estimated number of casualties arriving at the facility. As of February 1, 1980, the ASFs had supplied the information MAC requested, but the data had not been compared with casualty estimates.

Observations

We believe that existing military transportation capabilities should be used, to the extent possible, for transporting casualties to destination hospitals whether they are military, other Federal, or civilian facilities. This would enable the military to rely on its own known available resources and reduce dependence on EMS units of differing capabilities around the country. Requirements would include adequate numbers of military ambuses and other military emergency medical vehicles located at or quickly available to ASFs.

The patient transportation area is being studied by two groups. Maximus is studying civilian EMS resources, and MAC is studying military transportation. A DOD official told us that the studies would be coordinated to arrive at a decision on the proper mix of civilian and military transportation resources needed.

PATIENT ADMINISTRATION

The original CMCHS would have established a new, possibly duplicative, administrative structure to accomplish various functions that the existing military hospital system now performs in peacetime. The revised CMCHS has assigned administrative responsibility for patients in civilian hospitals to the linked DOD facility, rather than to the separate organizations envisioned under the original CMCHS plans.

Observations

We believe that DOD has taken the proper course of action. The revised plans build on existing administrative capabilities rather than establishing a duplicative system.

REIMBURSEMENT AND LIABILITY

According to AHA, reimbursement and liability may be the two most sensitive issues DOD will have to deal with in attempting to obtain medical care for casualties from civilian physicians and hospitals. The Maximus report noted that, in meeting with AHA staff to discuss the CMCHS concept, the consensus was that "there were grave problems facing it [the CMCHS concept] in a number of key areas, including payment mechanisms and malpractice suits."

According to the Maximus report, AHA believed that civilian hospitals, physicians, and others should be granted immunity from liability. Maximus concluded that it did not appear that CMCHS hospitals and personnel could be protected from malpractice suits by existing statutes. The Maximus report offered the following alternatives:

--Amend existing legislation to permit the Government to grant hospitals and physicians participating in CMCHS immunity from liability.

--Require CMCHS hospitals to provide adequate malpractice insurance coverage for their employees. The cost of such insurance could then be billed to the Government as part of the hospital charges.

The Maximus report left the issue open. It said that several participants in the "Nifty Nugget" exercise believed that malpractice would not be a significant issue in a wartime environment.

Regarding the issue of payment to civilian hospitals and physicians, the Maximus report recommended that DOD obtain care on a fee-for-service basis. According to the report, other reimbursement methods, such as those used by Medicare and Medicaid, would only hinder hospital and physician cooperation. DOD has a precedent for paying charges for civilian care of active duty patients, as Maximus pointed out. Military hospitals have established funds, such as those for supplemental care, which pay for military patients' care from civilian providers.

A DOD official told us that wartime reimbursement and liability situations would be extensions of its current peacetime practices for obtaining supplemental care for active duty members. He stated that hospitals and physicians have no problem with DOD's peacetime supplemental care practices, and he expects that no problem would be raised during wartime.

Observations

Unanswered questions remain regarding these issues, which were identified as major concerns by AHA. Failure to address and consistently resolve these issues could result in limited civilian hospital cooperation in DOD planning to care for wartime casualties.

While we do not endorse a particular reimbursement or liability system, we believe the plans should be as simple as possible so that civilian medical efforts can be directed toward patient treatment rather than paperwork.

COORDINATION WITH OTHER AGENCIES

A situation similar to that involving reimbursement and liability questions exists regarding coordination with other agencies. Both the original and revised CMCHS plans have unresolved issues concerning other agencies' wartime medical responsibilities.

Unresolved issues with the Federal agencies

FEMA has responsibilities for establishing and predicting the levels of need for certain resources during emergencies, and prioritizing conflicting needs if there is a shortage.

Federal agencies submit plans for resource claims to FEMA, which acts as overseer and arbiter for the President.

In the original CMCHS plan, Maximus did not believe that DOD had to submit the CMCHS plan to FEMA for approval. The reason, according to the Maximus report, was that CMCHS was not intended to hinder the delivery of civilian health care, and would not be subject to FEMA's resource allocation process.

In our opinion, any conflict large enough to generate the number of casualties that would necessitate activating a CMCHS would greatly affect civilian health care as well as other elements of society. Therefore, we believe if CMCHS had to be activated it is likely there would be considerable demand for health personnel and resources, and that FEMA and HHS would probably become involved in a resource allocation process.

HHS officials told us that the Department would have a key role in developing and implementing such a contingency system. The officials said that it is contrary to the Department's responsibilities for DOD and civil sector hospitals or DOD and VA to preallocate health resources without the Department's advised consent.

The Maximus report recognized another potential problem regarding the Selective Service System and the draft and suggested that deferments could be given to CMCHS participants. The report said, "It should be noted that the CMCHS plan could substantially impact on the pool of physicians available for mobilization." The report suggested that the Selective Service System become involved in CMCHS planning so that it would be aware of revised Armed Forces estimates for staff in general, and physicians in particular.

A DOD official told us that Selective Service System representatives have stated that short-term draft deferments would not be a problem for certain staff participating in CMCHS. However, a Selective Service System official, while acknowledging previous discussions with DOD regarding possible induction deferments or postponements, told us that either would require special authorization and would not be automatic.

Observations

The CMCHS concept seems to have been structured so that it could be implemented without involving or requiring the approval of other Federal agencies having wartime responsibilities. While this might simplify the system's implementation, it could also render it ineffective if other agencies with wartime responsibilities were to reduce the supply of physicians at the hospitals DOD was using. Therefore, we believe that any system for using civilian hospitals during wartime should be planned and developed recognizing the responsibilities and authority of other Federal agencies in a wartime setting.

In our opinion, recognizing the responsibilities and authority of other agencies highlights the value of looking for assistance within the Federal sector, since this is the area where the Government has greatest control over resources.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS AND OUR EVALUATION

CONCLUSIONS

A plan to use nonmilitary resources for medical treatment of returning wartime casualties is needed. However, several issues and unanswered questions regarding DOD's CMCHS implementation plans need attention.

The most important issue, in our opinion, is the extent of support VA can provide DOD in treating battlefield casualties. DOD's most recent plans have included VA's providing care for those casualties not expected to return to active duty. However, no estimates have been made of the expected number of such casualties. Moreover, VA has not given DOD estimates of its capabilities to treat such casualties under its current legislative responsibilities or its potential capabilities to treat casualties expected to return to duty.

VA cannot fully support DOD in treating casualties expected to return to duty without legislative modification to its current responsibilities. In our opinion, the Congress should include in VA's responsibilities an additional mission--to directly support DOD in treating battlefield casualties, including those expected to return to duty. With the addition of this mission, DOD and VA should develop systematic plans using available Federal medical resources to treat battlefield casualties, with civilian capability linked to both DOD and VA facilities. An excellent entry into civilian medical resources could be through VA's affiliated medical schools and hospitals.

In the Maximus study, which represented the foundation for DOD's original CMCHS plan, potential civilian sector medical capability was based on excess bed estimates in selected metropolitan areas of the country. Such estimates represented, in our opinion, limited indicators of medical care capability, since they did not identify beds which were actually available and staffed for use.

Also, Maximus assumed that the implementation of CMCHS would not adversely affect civilian medical care, including medical staff availability in hospitals participating in the system. Maximus suggested that DOD task participating civilian hospitals to assure that enough medical staff will be available to treat casualties. We believe the assumption regarding the impact of a system such as CMCHS on civilian sector medical staffing was unrealistic because it overlooked the potential demands which an intense military conflict could put on the Nation's medical resources.

DOD has recently revised its CMCHS plan. We see no evidence, however, that the revised plan addresses the unresolved issues of bed and staff availability any differently from the original plan proposed by Maximus. In fact, the military services will apparently have considerable flexibility in making their individual plans to secure civilian beds and staff, including using concepts recommended by Maximus.

We would not encourage DOD's identifying only excess beds for possible use in its contingency hospital system. Recognizing that an intense war would adversely affect health care delivery in this country, DOD should identify nonmilitary capability assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period. These actions would free beds and staff, which could then be available for treating battlefield casualties.

Other issues also need to be resolved as DOD begins to implement its revised CMCHS. Specifically, the optimal numbers and placement of ASFs in the United States need to be determined. First priority for ASFs should be near concentrations of military and VA medical capability with sufficient civilian resources available if needed. DOD also needs to determine the adequacy of ground transportation resources to transport patients from airports to destination hospitals.

In addition, other unresolved issues have the potential to limit implementation of a system such as CMCHS. These issues include (1) physician and hospital reimbursement and liability and (2) potential conflicting demands other Federal agencies may make on the same civilian medical resources in wartime.

VA as a potential wartime medical resource

Throughout this report, we have emphasized the need for DOD to look to VA as a potential source of medical assistance in time of war or conflict. DOD and VA have recently been discussing possible wartime coordination of resources, but some questions remain about VA's participation.

DOD currently plans for VA to care for casualties not expected to return to duty. However, VA's mission is to care for such veterans; therefore, such a plan involves no real change from VA's current primary responsibilities.

We believe VA should be much more involved in planning and caring for all returning battlefield casualties rather than only those not returning to duty.

Since VA is a Federal medical care system, one might presume that part of its mission is to directly support the treatment of battlefield casualties. This is apparently not the case. In fact, the Administrator of Veterans Affairs recently told DOD that VA would not be able to directly support DOD in treating wartime casualties in the United States, unless it is given that mission in other than a declared national emergency.

The Congress should add this mission to VA's current responsibilities, so that DOD and VA can take advantage of the time now available in peacetime to develop plans using available Federal medical resources to care for battlefield casualties. The alternative of waiting until a national emergency before fully involving VA could, in our opinion, result in

--unnecessary confusion during mobilization regarding where returning casualties should be sent for medical care,

--underuse of VA's medical capabilities during war or conflict,

--inability of DOD to know what the total Federal wartime medical capability is to identify the shortage which needs to be made up by the civilian sector, and

--unnecessary effort and expense by DOD to identify and contract for civilian medical resources.

In our opinion, the Nation should prepare for a possible conflict by planning to appropriately use Federal medical resources before calling on civilian resources. Major DOD and

VA hospitals could provide acute care to returning casualties. Smaller DOD and VA hospitals could provide convalescent care, enabling larger hospitals to receive more acute care casualties as patients are transferred to convalescent facilities. Civilian hospitals could handle patients divested from the Federal systems and provide additional capability for casualties as needed.

We believe that a contingency hospital system which makes use of VA's medical resources for all categories of returning casualties would be an efficient and effective use of Federal medical capability. Moreover, we believe that a strong peacetime medical resource sharing program, such as we recommended in June 1978, could provide a sound foundation for establishing effective working relationships between VA and DOD, which could be invaluable in the event of war. (See p. 15.)

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress enact legislation which provides that both DOD and VA fully participate in Federal medical planning for and care of returning wartime casualties. Such legislation should:

- --Give VA the mission of providing direct medical support to DOD for treating all categories of battlefield casualties.
- --Place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.
- --Remove numerous obstacles to interagency sharing, as we previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system.

RECOMMENDATIONS TO DOD AND VA

We recommend that the Secretary of Defense and the Administrator of Veterans Affairs jointly:

- --Develop and establish the framework for a military-VA-civilian contingency hospital system. As part of this development, establish a mechanism for obtaining civilian medical care capability that (1) recognizes the responsibilities and authority of FEMA, HHS, and other

Federal agencies during war or conflict and (2) adequately considers other unresolved issues, such as physician reimbursement and liability, and ground transportation availability.

--Analyze DOD's and VA's medical care resources to determine the Federal patient treatment capability on a time-phased basis. This analysis should be made first near existing DOD aeromedical staging facilities, but should also include other locations where there are large concentrations of DOD and VA medical resources.

--Identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) nonemergency admissions are restricted during the war surge period.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary:

--Compare the medical care requirements calculated under various wartime scenarios with available Federal medical resources to determine how much and what type of civilian medical care capability would be needed to augment Federal capability.

--Determine the optimal number and placement of U.S. aeromedical staging facilities, with emphasis on locations near concentrations of military and VA medical resources.

--In concert with other agencies having contingency planning responsibilities, assume overall coordinating responsibility for plans jointly developed by DOD and VA using Federal medical resources and necessary civilian medical capability under the military-VA-civilian contingency hospital system.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator:

--Provide estimates to DOD concerning its potential capabilities, in terms of both facilities and staffing, to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty. Such estimates should be based on the assumptions that patients would be discharged early whenever possible and nonemergency admissions would be restricted during the war surge period. These estimates should be developed through the joint DOD-VA planning effort to establish a military-VA-civilian contingency hospital system.

--Ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties.

AGENCY COMMENTS AND OUR EVALUATION

We received written comments on our draft report from DOD, VA, and FEMA. HHS officials responsible for the Department's emergency coordination activities and Selective Service System officials also provided us with comments on the draft report.

DOD comments

The Assistant Secretary of Defense (Health Affairs), in a letter dated May 14, 1980 (see app. III), stated that DOD generally agreed with our recommendations and that actions necessary to implement those to the Secretary of Defense have already been initiated. DOD stated that it has long looked to VA for wartime support and that an active dialogue is now in progress to effect the necessary wartime planning between the two organizations. The Assistant Secretary stated that DOD has only recently begun to look to the civil sector for contingency augmentation beyond combined DOD and VA capabilities.

DOD did not comment on the specific recommendations we made for joint implementation by the Secretary of Defense and the Administrator of Veterans Affairs other than noting that an active dialogue between the agencies is taking place. Notwithstanding such a dialogue, there are strong indications that DOD plans to proceed to implement an only slightly modified version of its original CMCHS plan. For example, recently published remarks by the Special Assistant to the Assistant Secretary responsible for initial development of CMCHS indicate that DOD still intends to secure excess beds in scattered civilian hospitals, and to assume that delivery of civilian medical care would not be interrupted. Neither the Assistant Secretary in his comments, nor the Special Assistant in his remarks, mentioned the inclusion of VA as a full partner in the planning process for caring for wartime casualties.

We believe that DOD's plans to secure small numbers of excess civilian beds and the assumption that civilian care would remain essentially uninterrupted are unrealistic in planning for a contingency hospital system. We continue to believe that a system such as CMCHS should be a military-VA-civilian contingency hospital system. DOD and VA should, together, develop systematic plans for using Federal medical resources to treat battlefield casualties, with civilian capability linked to both DOD and VA facilities.

DOD also stated that it is incorrect for us to assert that it has looked primarily to civilian medical resources to meet anticipated shortfalls should the United States become involved in war. DOD noted that it and VA executed a memorandum of understanding in 1965 under which VA beds would be made available to DOD in time of national emergency not involving an attack on the United States.

We are aware of the memorandum. However, in its report concerning VA's capabilities, Maximus stated the views of VA staff members that "The 1965 agreement was limited in scope and purpose, and may no longer be valid or useful." The report also summarized efforts to develop the emergency planning which was anticipated by the 1965 agreement. Maximus summarized the ultimate development of emergency planning as follows:

> "In any event, by early 1966 joint development discussions were abandoned. In early 1969, an unsuccessful effort was made to reserve a block of VA beds for DOD use. Since that time, neither VA nor DOD has updated any list of capabilities or anticipated needs under this agreement. And no firm commitment was ever made on the exact size or nature of capabilities to be requested or provided."

In view of the above, we believe the 1965 memorandum of understanding has not contributed substantially to joint DOD and VA medical contingency planning.

DOD also stated that, during the 1978 Nifty Nugget exercise, VA made a number of beds available to treat DOD casualties. However, Maximus in its original CMCHS report stated that:

> "The initial plans for CMCHS play in Nifty Nugget had not included either Public Health Service or Veterans Administration facilities. However, in late August, emergency preparedness officials who were the VA players in the exercise found out about the exercise of CMCHS and, after being briefed on the system expressed a desire to be included in the play. Thus, arrangements were made to incorporate them into the exercise flow." (Emphasis added.)

As shown above, VA officials asked to be included in the exercise only after they found out about it by chance rather than because of any DOD coordinating action. The Maximus report on VA stated that "Subsequently DOD sponsored this study to explore ways of formalizing a working contingency relationship with VA." Thus, only after VA asked to participate in the CMCHS part of the Nifty Nugget exercise did DOD sponsor an exploratory study of VA's capabilities.

VA comments

By letter dated May 13, 1980 (see app. IV), the Administrator of Veterans Affairs stated that VA agreed with the need for legislative changes to remove statutory obstacles to VA's meeting DOD's contingency needs. However, he also expressed concern about several specific aspects of our recommendations.

First, the Administrator said he was concerned that legislation such as we are recommending should not be misconstrued to require an explicit change in VA's fundamental mission. Rather, VA believes there is a need for sufficient flexibility to permit VA to serve a contingency support role, unhindered by current restrictions in law and regulation.

We support VA's position and do not intend that VA's basic mission be diminished. Rather, we believe that mission should be expanded to include responsibility for providing direct support to DOD in treating battlefield casualties, including those expected to return to duty.

Second, VA expressed concern that several of the recommendations may be construed as suggesting that VA become the spokesman for part of DOD's contingency planning. VA recommended that DOD be charged with coordinating responsibility for contacting and developing emergency contingency plans with civilian hospitals. VA also stated that other agencies, such as FEMA, HHS, and the Selective Service System, should be involved in determining the extent of support the civilian health care community is willing and prepared to provide.

We agree with VA's suggestions and have added a recommendation to the Secretary of Defense to address this matter. We believe, however, that VA could be extremely valuable in initiating and fostering relationships between its affiliated hospitals and DOD. VA should determine the extent to which affiliated hospitals could assist VA in treating battlefield casualties as stated in our recommendation to the Administrator.

Third, VA stated its belief that it would be premature to provide DOD with capability estimates as we recommended. VA stated that estimates of the number of beds that might be available should be determined through a joint DOD-VA planning effort. We agree and have modified our recommendation to the Administrator.

Finally, VA expressed concern about the authority for providing VA administrative and clerical staff to bolster DOD's wartime staffing needs. VA stated that there may be some difficulty in planning on staff availability particularly without legislation which would subordinate veteran health care priorities to caring for battlefield casualties.

Our recommendation to the Congress regarding the placement of battlefield casualties in VA's priority for care was developed to provide authority for such staffing actions by VA.

FEMA comments

By letter dated May 2, 1980 (see app. V), FEMA's Associate Director for Plans and Preparedness generally agreed with our conclusions and recommendations, but was concerned that FEMA and HHS had been excluded from the planning and policymaking process involved in CMCHS. FEMA pointed to several major responsibilities assigned to both FEMA and HHS by the President regarding wartime medical resource allocations.

In performing this study, we were concerned about how these and other agencies would influence medical resource use during wartime and DOD's apparent lack of coordination with them as it planned and developed CMCHS. Our October 1979 report to DOD (see app. I) addressed this and other unresolved issues and recommended that DOD suspend actions to establish CMCHS until they were resolved. However, DOD has proceeded with the CMCHS development apparently without coordination with these agencies.

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-133044 OCTOBER 26, 1979

The Honorable Harold Brown
The Secretary of Defense

Dear Mr. Secretary:

Subject: Implementation of a Civilian-Military Contingency Hospital System Should be Suspended (HRD-80-21)

During the past several months, we have been reviewing DOD's plans to use nonmilitary hospitals to provide medical care to wartime casualties. While we have not finished our review, we have a number of concerns about these plans that we want to bring to your attention before a specific plan is implemented.

On March 15, 1979, Maximus, Inc., issued a final report to the Office of Assistant Secretary of Defense (Health Affairs) entitled "Study of the Problems Associated with Reliance on Civilian Medical Manpower and Non-DOD Facilities During Periods of National Emergency, Mobilization and War." We understand that this study represents the foundation for the Civilian-Military Contingency Hospital System (CMCHS) to be implemented beginning this month under the Assistant Secretary's direction.

Based on our work to date, we have identified several basic problems in the Maximus report which DOD has not resolved and which, therefore, tend to weaken its validity as a foundation for CMCHS. Some of our concerns are:

1. The report identified excess acute care beds in 41 U.S. metropolitan areas. The excess capacity was determined by taking 15 percent of the total bed capacity of certain hospitals, as shown in the 1976 issue of the American Hospital Association's hospital guide. However, only six hospitals located in 2 of the 41 metropolitan areas were visited.

(101017)

Therefore, little is known about whether those beds are actually available or whether there is equipment and staff to operate them. Similarly, the impact that rapid population growth in certain areas has had on excess capacity has not been analyzed.

2. Even if the excess acute care beds identified in the Maximus report were available and staffed, no analysis has been made of the impact of divesting non-active-duty patients from military hospitals to civilian hospitals during mobilization. Our preliminary analysis showed that, in several major metropolitan areas, the divesting process would use much of the excess bed capacity believed available for the implementation of the system. Because of this consideration, DOD may not be able to fully rely on the areas identified by Maximus to have the capability to treat casualties.

3. The CMCHS as recommended by Maximus will concentrate on obtaining acute care beds, but not convalescent beds. However, some military officials we talked to believe that many convalescent beds will also be needed.

4. The Maximus study did not determine whether civilian hospitals in general would participate in CMCHS. A Maximus official told us that hospitals' willingness to participate in the system will be tested as part of the system's implementation. Although Maximus coordinated its study with the American Hospital Association, the Association had reservations about many aspects of the CMCHS concept. Also, according to a Maximus official, there has been no coordination with the American Medical Association, the American College of Surgeons, or the American Association of Medical Colleges. We believe these groups--because of their influence on the physicians needed to staff the beds in civilian hospitals--would play a major role in determining the ultimate success or failure of the CMCHS concept's implementation.

5. The Maximus report left various issues unresolved concerning how the Selective Service System, the Federal Emergency Management Agency, and the Department of Health, Education, and Welfare would influence the use of civilian medical resources during wartime. These agencies have responsibilities which would affect the same resources that CMCHS, if implemented, would rely on during wartime.

6. CMCHS as described by Maximus would be a new organization with responsibility for carrying out various functions that may duplicate those of existing military organizations. The military services raised this objection when the CMCHS draft implementation directive was circulated for comment.

7. The Maximus study was limited to assessing civil sector capability for DOD's use during wartime. Through another contract with DOD, Maximus is assessing what wartime capability the Veterans Administration could provide to DOD. In our opinion, DOD ought to determine the full extent of available Federal resources before beginning to contract for private sector capability.

We are summarizing in another document the results of our work to date concerning the above issues and others relating to DOD's use of nonmilitary medical facilities to care for wartime casualties. As you know, the Chairmen of the Subcommittees on Military Personnel and Military Compensation of the House Armed Services Committee, in a July 17, 1979, letter, stated their intention to hold hearings on the development and implications of a DOD draft report on the wartime medical posture. We understand that the issues raised during our work will also be discussed during those hearings, which are expected to be held in the near future.

RECOMMENDATION

Because many basic questions have not yet been resolved concerning the use of nonmilitary hospitals to provide medical care to wartime casualties, we believe it is premature to establish a new organization to interface with civilian hospitals and begin contracting for medical care capability. Accordingly, we recommend that you suspend actions to establish CMCHS at least until the Subcommittee Chairmen have held their planned hearings.

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As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen of the four above-mentioned Committees and the House and Senate Committees on Armed Services and to the Director, Office of Management and Budget. We are also sending copies to the Chairmen of the Military Personnel and Military Compensation Subcommittees and to Congressman Robin Beard, who requested our review.

We appreciate the cooperation and assistance provided by DOD personnel during our ongoing review. We will be glad to discuss any questions with you or your representatives.

Sincerely yours,

Gregory J. Ahart
Director

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

10 DEC 1979

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

This is in reply to your letter of October 25, 1979, to the Secretary of Defense regarding "Implementation of a Civilian-Military Contingency Hospital System Should Be Suspended (HRD-80-21)" (OSD Case #5309).

Significant shortfalls exist in military medical preparedness for war. Several studies have been conducted to quantify and to validate these shortfalls, as well as to examine various options to overcome them.

The Maximus study referred to in your letter was an initial investigation of the feasibility of using civilian hospitals as one source of the needed capabilities. The study identified what appears to be a workable, extremely low-cost method of ensuring rapid expansion of hospital bed capacity in the continental United States (CONUS) for support of military contingencies. The issues raised in your letter have been examined and each is addressed in the enclosure. We do not agree with your assertion that it is premature to begin establishing civilian linkages or your recommendation that DoD suspend actions to establish CMCHS. Our position is that:

o Basic questions will not be resolved concerning the use of non-military hospitals until civilian linkages are established.

o It is clear that DoD does not have adequate bed capability to care for casualties arising from a major short-warning contingency.

o It is also clear that other Federal hospitals will be unable to fill the total deficit;

c Therefore some other source of CONUS bed capability is required;

o We have concluded that civilian hospitals offer the only viable solution;

o The lack of alternatives and the issues you raise further emphasize the urgent need for prompt efforts to provide effective links to civilian health capability.

It is estimated that contracting activities can begin in approximately six months. In the interim, we will be pleased to discuss our progress with members of your staff.

Sincerely,

Vernon McKenzie
Principal Deputy Assistant Secretary

Enclosure

COMMENT ON SPECIFIC ISSUES

1. Absolute knowledge of bed availability lacking:

Because of seasonal variations, cost containment activities, and special hospital situations, the data about bed availability always lags behind the reality of the dynamic U.S. health system. However, the CMCHS concept intends that each individual civilian hospital make its own decision about the extent of it participation, if any. Until actual linkage mechanisms (contracts) are tested, we will not have certain knowledge of bed availability or willingness to participate. The definitive nature and small cost of such contracts makes them an attractive alternative to continuing expensive studies which further delay implementation.

2. Impact of divesting non-active duty patients from military hospitals:

CMCHS commitments are intended to cover active duty military patients only. Military hospitals are also required to plan for moving hospitalized eligible non-active duty beneficiaries into local civilian hospitals in order to free staff for transfer overseas or for receipt of military patients. Special coordination during implementation of CMCHS should prevent duplication or overload of civilian hospital commitments.

3. Active vs. convalescent beds:

The initial need in a contingency will be for acute care beds. CMCHS is intended to provide these beds. The need for and possible alternative sources of convalescent beds are presently being addressed.

4. Hospital willingness to participate:

While absolute certainty is lacking, all of our evidence on this subject suggests that, in general, hospitals will be pleased to assist in the care of war casualties. A significant aspect of the CMCHS implementation plan calls for continuing coordination with the American Hospital Association, the American Medical Association and other appropriate health groups.

5. Medical manpower and resource issues unresolved:

The Maximus report documented these issues, which were raised during Exercise NIFTY NUGGET. Resolution actions are part of the CMCHS implementation plan.

(Enclosure)

6. Organizational duplication:

The plan being developed will require an initial concentration of policy and management oversight during program implementation efforts. Once established, however, the system will be managed and operated by the military departments with no organizational duplication.

7. Determine full availability of Federal beds before contracting: Assessment of VA and PHS bed availability is nearing completion. However, there are significant problems associated with military use of these Federal beds. Even the most optimistic availability of these assets would not obviate the need for the civilian bed levels proposed for CMCHS.

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

HEALTH AFFAIRS

14 MAY 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in reply to your letter of April 3, 1980 to the Secretary of Defense regarding your draft report entitled, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System" (GAO Code 101017) (OSD Case #5411).

We are in general agreement with the recommendations contained in your draft report and have already initiated the actions necessary to implement the recommendations to the Secretary of Defense. We are pleased that you concur with the changes that have taken place in the CMCHS concept as it has evolved from the point of departure recommended by the contractor. The constructive efforts of the Services and OSD staff elements during the coordination process of the first draft DoD Directive were most helpful in refining the concept to its present state.

We are also pleased that you agree with the courses of action we have outlined to address the remaining unresolved issues we identified to you. We anticipate rapid resolution of these issues, when the CMCHS director and deputy director can dedicate their full-time to these efforts.

It is, however, incorrect to assert that DoD has looked primarily to civilian medical resources to meet anticipated shortfalls should the U.S. become involved in war. DoD and the VA executed a memorandum of understanding in 1965 under which VA beds would be made available to DoD in time of national emergency not involving attack on the United States. During Nifty Nugget 78, the VA made a sizable number of beds available to treat DoD casualties. As your report states, active dialogue is now in progress to effect the necessary wartime planning between the two organizations. It is much more accurate to state that DoD has long looked to the VA for wartime support and has only recently begun to look to the civil sector for contingency augmentation beyond the combined DoD and VA capabilities.

Sincerely,

for John H. Moxley III, M.D.

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

MAY 13 1980

Mr. Gregory J. Ahart
Director, Human Resources Division
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

Thank you for the opportunity to review your April 3, 1980 draft report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System," which states the Department of Defense (DoD) is developing a Civilian-Military Contingency Hospital System for medical treatment of battlefield casualties. The General Accounting Office (GAO) report states that while such a system is necessary because DoD has insufficient resources to treat anticipated casualties, several issues and unanswered questions regarding DoD's implementation plans need immediate attention. In GAO's opinion, the most important issue is the extent of support the Veterans Administration (VA) will provide DoD in treating casualties. DoD's most recent plans have considered limited assistance; however, GAO found that VA cannot fully support DoD without legislative modifications to its current responsibilities and recommends that the Congress enact needed legislation.

We agree that the question of the extent to which VA can support DoD in treating returning battlefield casualties is a most important issue in wartime contingency planning. As this Agency has advised DoD health planners, there are statutory obstacles to VA's meeting all of the Department's contingency needs. We concur with the need for legislative change. Earlier discussions about the incompatibility between the VA's mission and a significant role in supporting DoD in treating battlefield casualties who are expected to return to duty, should not be misconstrued to require an explicit change in the fundamental VA mission set forth at 38 U.S.C. section 201. The basic statutory mission of this agency (in section 201) and its Department of Medicine and Surgery (in section 4101) need not be altered. Rather, there is a need, recognized by this agency and GAO, for sufficient flexibility to permit VA to serve a support role, unhindered by current restrictions in law and regulation.

The report recommends that the Secretary of Defense and I jointly:

—develop and establish the framework for a military-VA-civilian contingency hospital system. As part of this development, establish a mechanism for obtaining civilian medical care capability if needed, that (1) recognizes the responsibilities and authority of other Federal agencies during war or conflict, and (2) adequately considers other unresolved issues such as physician reimbursement and liability, and ground transportation availability;

--identify Federal and civilian capability that could be provided assuming that (1) patients are discharged early whenever possible and (2) non-emergency admissions are restricted during the war surge period;

The GAO also recommends that I:

--ascertain the extent to which VA's affiliated hospitals would be able to assist VA in treating battlefield casualties.

We believe these might be construed to direct that the VA become the spokesman for DoD in contacting and developing emergency contingency plans with civilian hospitals in VA communities, and specifically, those with whom we are affiliated. While we fully support and will cooperate with DoD's efforts to determine the civilian health care capability to meet military needs in time of national emergency, we recommend that DoD be charged with this coordinating responsibility. The Department of Health and Human Services, the Selective Service System, and the Federal Emergency Management Agency, as cited on page 5 of the report, should also be involved in determining the extent of support the civilian health care community is willing and prepared to commit. These agencies would then be cognizant of the resources they will be required to provide VA in support of any agreements which evolve.

The report also recommends that I:

--provide estimates to DoD concerning its potential capabilities, in terms of both facilities and staffing, to treat returning battlefield casualties regardless of whether those casualties would be expected to return to duty or not. Such estimates should be based on the assumptions that patients would be discharged early whenever possible and non-emergency admissions would be restricted during the war surge period.

We believe any indication of the number of beds that might be available is premature at this time. This should be done through a joint DoD/VA planning effort.

Page 23 of the report carries the statement that VA administrative and clerical employees could be made available to assist DoD with casualties as one means of bolstering that Department's wartime staffing needs. The only authority we can identify for such an initiative lies in section 686 of title 31, U.S.C. That provision authorizes "cross servicing agreements," including the purchase of services by one department or agency from another, and presupposes the availability of the personnel.

While the "provider" agency has the discretion of determining if the staff is available, there would appear to be some difficulty in planning on that availability. This difficulty is compounded by the absence of legislation which would permit the veteran health care mission to be subordinated to meeting DoD's health care needs.

The recommendations in this GAO report are not inconsistent with the VA's interests and past efforts, and, as the report acknowledges, DoD and VA officials have been working toward wartime contingency arrangements.

Indicative of this fact, for example, our General Counsel and his Department of Defense counterpart have communicated recently regarding the specific legislative barriers to be hurdled if satisfactory contingency planning is to be realized.

Sincerely,

MAX CLELAND
Administrator

FEDERAL EMERGENCY MANAGEMENT AGENCY
Washington, D.C. 20472

MAY 2 1980

Mr. Henry Eschwege
Director
Community and Economic Development Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Eschwege:

Thank you for the opportunity to review and comment on the draft report, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System".

We agree, in general, with the conclusions and recommendations of the draft. However, we are deeply concerned about the exclusion of the Federal Emergency Management Agency (FEMA) and the Department of Health and Human Services (HHS) in the planning and policy-making processes involved. While the draft report alludes to FEMA's role on pp 34-35, the Digest and Conclusions and Recommendations lack any reference to this subject. Similarly, we noted no citations or discussions of the HHS (formerly HEW) responsibilities and interests in this matter.

In view of the important responsibilities of FEMA and HHS, as set forth in Executive Orders 12148 and 11490 respectively, and other authorities, it is unclear why they have been omitted in past and current Civilian-Military Contingency Hospital System (CMCHS) and related planning activity.

The crucial issue which the report fails to address adequately is the need for central control, coordination, and management of the planning for and the actual use of the Nation's essential resources likely to be required in emergencies (e.g., hospital beds). FEMA was created to perform this important function for the President. HHS has the assigned responsibility, under FEMA's guidance, to develop plans and programs for mobilization of the Nation's health resources (including hospital beds).

In our view, the Secretary of Health and Human Services, along with the Administrator of Veterans Affairs, should work jointly with the Secretary of Defense and others, as necessary, to develop and establish the framework for a Military-Civilian Contingency Hospital System. FEMA should participate as the coordinator and function in its adjudication role in the event unresolved issues develop.

We believe this arrangement would be more effective in solving DOD's hospitalization and evacuation problems, while concurrently ensuring that such matters as the following will be factored into the planning equation:

o consideration that the war scenario may progress to an attack on the CONUS, thus broadening the battlefield; in which case standby plans for mobilization and utilization of health resources may conflict with the CMCHS concept.

o a Presidential priority assigned to Crisis Relocation Planning, especially with respect to hospitals, may be incompatible with CMCHS planning.

o standby health workforce mobilization policies and plans will be supportive of overall preparedness objectives.

Finally, we endorse strongly the concept of sharing and partnership within the Federal Executive Branch in the development of our overall preparedness posture and are prepared to contribute to the solution of DOD's problems in keeping with our responsibilities and resources.

Sincerely yours,

Frank A. Camm
Associate Director for
Plans and Preparedness

APPENDIX B

97TH CONGRESS
1st Session

SENATE

REPORT
No. 97-137

THE FEDERAL INTERAGENCY MEDICAL RESOURCES SHARING AND COORDINATION ACT OF 1981

JUNE 15 (legislative day, JUNE 1), 1981.—Ordered to be printed

Mr. PERCY, from the Committee on Governmental Affairs, submitted the following

REPORT

[To accompany S. 266]

The Committee on Governmental Affairs, to which was referred the bill (S. 266) to establish a Federal Interagency Medical Resources Committee to insure the most efficient and effective use of Federal direct health care resources, having considered the same, reports favorably thereon without amendments and recommends that the bill do pass.

PURPOSE OF LEGISLATION

It is the purpose of this Act to encourage and enable the Veterans Administration, Department of Defense, and other Federal direct health care providers to make more efficient use of their medical resources through greater interagency sharing and coordination.

BACKGROUND

In recent years, increasing concern has been expressed in the Congress and elsewhere over the rapidly increasing costs of medical care in the Nation. As in the private sector, Federal agencies' costs to provide health care directly to eligible beneficiaries have continued to rise, and substantial efforts have been made to explore ways of reducing these costs without adversely affecting the quality of care.

Shortly after enactment of the National Health Planning and Resources Development Act of 1974, requiring non-Federal hospitals to coordinate and plan the use of their medical resources, the General Accounting Office began an extensive examination of the possibilities for Federal hospitals to do the same.

GAO study

The GAO's 1978 report on Federal interagency sharing clearly identified the tremendous opportunities for reducing Federal direct health care costs, now exceeding $10 billion a year and enhancing the quality of health care through greater interagency sharing and coordination.

The Veterans Administration, Defense Department, and Public Health Service operate more than 300 hospitals across the United States. The GAO's investigation of this health care system included a review of 50 Federal medical facilities, and documented dozens of cases of opportunities for greater sharing. For instance:

> The Federal Government's Public Health Service Hospital in Seattle has a spinal cord injury center just 2 miles from a VA hospital that lacks such facilities. In one year, the VA transported 19 spinal cord injury patients to Long Beach, California because regulations required patients to be treated within the same agency. The Seattle VA is planning to construct its own $7 million spinal cord center just 2 miles from the other facility.
>
> Twtney-one million dollars worth of CT scanner equipment was being proposed for Federal purchase without a coordinated Federal approach to planning and use of the equipment.
>
> Federal agencies planned to modernize or establish new cancer treatment capabilities costing about $16 million without coordinating the 23 locations where radiation therapy could be provided more efficiently through cross-agency sharing.

The GAO defined several legal and administrative obstacles blocking greater coordination. These opportunities and many others were not being taken advantage of because the following obstacles precluded attempts or inhibited the efforts of agencies to implement sharing arrangements:

> Restrictive laws limiting the types of resources that can be shared between Federal agencies, and what beneficiaries can be treated in another agency's facility.
>
> Conflicting agency regulations, policies, and procedures. Most prominent are inconsistent and unequal reimbursement methods.
>
> Disincentives at the hospital director level. For example, when a VA hosptial director agrees to provide a service to a Defense Department hospital, the reimbursement for that service goes to Washington rather than to the VA hospital providing the service.
>
> The absence of a specific legislative policy for interagency sharing which would remove these obstacles.

The GAO concluded that while Federal agencies should address these administrative obstacles, greater interagency sharing would require legislation that would establish a legislative policy for sharing and planning, as well as remove all of the legal and administrative barriers identified in their report.

Federal Health Resources Sharing Committee formed

During the GAO's investigation, the Veterans' Administration, Department of Defense, and Public Health Service formed the "Federal Health Resource Sharing Committee" (FHRSC). FHRSC's mandate was to assess the accuracy of GAO's findings, then implement the recommendations they felt were appropriate. The FHRSC has verified the GAO's 1978 findings, made attempts to implement sharing, and made legislative recommendations.

The Federal Health Resource Sharing Committee made some progress in verifying and expanding on the findings of the 1978 GAO report. Also, they unquestionably helped raise the level of awareness in these agencies with regard to this issue and have been of great assistance in preparing legislation. However, the Committee has made little substantive progress in implementing sharing arrangements or planning for future development. This is partly due to the low priority assigned the Committee, but more important, they have run into the same obstacles to sharing described in GAO's report two years ago.

Governmental affairs investigation

The Governmental Affairs staff undertook its own investigation of sharing opportunities and obstacles to sharing in several locations. In one case, near Chicago, they found that the Navy is spending $25 million a year operating the Great Lakes hospital, a relatively modern facility, at only a 20 percent occupancy rate due to a serious doctor shortage. The shortage is also forcing them to spend over $3 million a year to refer patients to the private sector and contract for certain specialists.

A VA hospital less than a mile away is experiencing the opposite problem: while they have a good supply of physicians, due in part to a University affiliation, their aged and inefficient buildings are in need of millions of dollars worth of improvements. Currently, VA patients are unable to use Navy beds, and, with few exceptions, Navy patients cannot see VA doctors.

Although no comprehensive study of all sharing opportunities was made, a review of the locations of over 300 Federal hospitals indicates that as many as 202, in 73 locations, may lend themselves to some form of sharing.

While there are existing laws allowing sharing among Federal providers, they clearly have not been effective in promoting comprehensive sharing of existing medical resources.

For example, the Veterans' Administration is allowed to share some resources and services under section 5053 of Title 38, U.S.C., one of two authorities under which they may share. While VA shared over $20 million in services in 1979, only $17,000 of this amount represented sharing arrangements with the Defense Department, the other major Federal direct health care provider (the remainder was with non-Federal providers). The VA has testified that it has some sharing arrangements with other Federal providers under other authorities, but was unable to specify the extent of these arrangements. Nor have existing authorities encouraged systematic cross-agency planning of hospital construction and renovation, or acquisition of expensive medical equipment. For instance, the Veterans' Administration recently reported on its five year plans for medical facility construction calling for over $4 billion in expenditures. The Committee could find little indication that these plans have been coordinated with other Federal direct health care providers.

The Committee feels that the tremendous potential for reducing Federal direct health care costs and enhancing the quality of care to beneficiaries through greater coordination among Federal direct health care providers, particularly between the Veterans' Administration and Department of Defense, has been clearly documented by years of study by the GAO, FHRSC, Congress, and others. Further, the enactment of legislative remedies to remove impediments to sharing, provide incentives at the local level, and establish a Congressional policy for sharing and coordination is long overdue.

The Committee sugggests that the GAO continue its oversight role in the area of interagency health resource sharing by monitoring the implementation of this Act.

SUMMARY OF HEARING

Although no hearings have been held this session on S. 266, a hearing on a nearly identical bill (S. 2958) was conducted on July 30, 1979. Nine witnesses appeared before the Committee at this hearing.

The first panel was composed of General Accounting Office representatives. They discussed the findings and recommendation of their reports on interagency sharing and their views on S. 2958.

The GAO has long been an advocate of more cost-effective use of existing Federal medical resources, and greater planning in any future construction or equipment acquisition. They viewed S. 2958 as the needed legislative statement to encourage and enable the most efficient use of Federal medical resources while maintaining, and perhaps, enhancing the quality of the care.

The GAO suggested that S. 2958 include all Federal direct health providers. S. 266 reflects this suggestion.

The second panel consisted of two Federal hospital administrators. A Veterans' Administration hospital administrator and Navy hospital Commander, both from San Diego, described their attempts to implement several sharing arrangements between these two facilities, and how legal and administrative obstacles prevented the implementation of these arrangements. For instance, the Veterans' Administration offered use of its "Argon Laser" device, used to treat eye disorders, to the Navy at no charge. The unit was being used primarily for research at the Veterans Hospital, and was unused several mornings each week. The Navy had no laser unit of their own at the time. This factor forced the Navy to buy treatments in the private sector where long delays in obtaining treatment on a private hospital's device was causing harm to some Navy patients. Thus, the Navy Commander agreed to the VA's proposal which would save the Navy and the taxpayer money. Also, having the time set aside at the VA would assure prompt treatment.

The Veterans Administration in Washington rejected the proposal on the grounds that a standard OMB rate of $39 per visit would have to be charged to the Navy, regardless of the fact that the use of the machine would have cost almost nothing to the San Diego Veterans Administration. The rate set by Washington turned out to be higher than the rate the Navy was paying in the private sector, thus, the Navy rejected the arrangement. The Navy has now bought its own laser at a cost of nearly $30,000.

The witnesses testified that another proposed arrangement to share cardiac cathetarization services failed for similar reasons. Also, in response to questions, it was disclosed that the Navy's $293 million hospital in San Diego is being planned with little or no coordination with the Veterans Administration. In radiation therapy alone, the Veterans Hospital is spending $250,000 annually on private sector care. The new facility is planning their own radiation therapy capability without regard for VA's needs in the area.

These local administrators, along with others across the United States who submitted comments strongly endorsed legislation to encourage greater sharing.

The former chairman of the Federal Health Resource Sharing Committee (FHRSC), formed in 1978 by the Federal health care providers to study the obstacles to sharing and whether legislation is needed, testified to their findings and recommendations.

FHRSC has concluded that the primary impediments to health sharing are: incompatible reimbursement methodologies, insufficient local authority in negotiating sharing agreements, and the lack of legal authority to treat beneficiaries of other Federal agencies.

The FHRSC testified that legislation is needed which would remove these impediments, as well as provide incentives for commanders and directors of Federal health facilities to enter into health sharing arrangements with other Federal providers.

The next panel included the Assistant Secretary of Defense (Health Affairs), and the Surgeons General of the Army, Air Force, and Navy. The Defense officials testified that while some sharing is already occuring, particularly within the three military services, maximized sharing among all Federal providers will require legislation. The Defense Department favors the enactment of legislation which would maximize sharing.

The final witness was the Chief Medical Director of the Veterans Administration. The Veterans Administration strongly supported the objective of increased sharing among Federal direct health care providers. It recognizes that certain legal, administrative, and other disincentives mitigate against maximized interagency sharing and coordination.

The medical Director stated that with certain changes and guarantees that the priority of access be assured, the VA would be pleased to support sharing legislation. The VA described S. 2958 as one means of encouraging an important goal. Many of their suggestions have been incorporated in S. 266.

OTHER COMMENTS

The Committee received written comments from four Veterans service organizations. Of these, the Disabled American Veterans and AMVETS endorsed S. 2958.

The American Legion supports the concept of sharing Federal Medical Resources where feasible, yet would prefer that only Executive authority be used to cause the Veterans Administration and Department of Defense to achieve maximum utilization of available resources. The Committee is encouraged by the Legion's support for greater sharing. With regard to their preference for Executive action, it should be pointed out that the GAO, Defense Department, Veterans Administration, OMB, local hospital administrators, and the Federal Health Resource Sharing Committee have all cited statutory limitations blocking efforts of Federal agencies to make the most efficient use of their medical resources.

The Paralyzed American Veterans also agreed with the concept of S. 2958 because of the need for greater interagency sharing. However, they feel that additional safeguards need to be included to ensure that quality health care and the integrity of the Veterans Administration is maintained. Because of such concerns, language was included in S. 266 which specifically prohibits sharing which would adversely affect the quality of, or the established priority of, care provided.

WITNESS LIST

Mr. Gregory Ahart, Director, Human Resources Division, General Accounting Office.

Rear Admiral J. William Cox, Commanding Officer, Naval Regional Medical Center, San Diego.

Mr. F. Todd Yates, Chief of Supply Service, Veterans Medical Center, San Diego.

General Quinn H. Becker, Former Chairman, Federal Health Resource Sharing Committee.

Dr. John Moxley, Assistant Secretary of Defense for Health Affairs.

Vice Admiral W. P. Arentzen, Surgeon General, United States Navy.

Lieutenant General Charles C. Pixley, Surgeon General, United States Army.

Lieutenant General P. W. Myers, Surgeon General, United States Air Force.

Dr. Donald L. Custis, Chief Medical Director, Department of Medicine and Surgery, Veterans Administration.

COMMENTS ON S. 266

The Committee received written comments on S. 266 from the Veterans Administration and the General Accounting Office.

The Veterans Administration strongly supports the goal of achieving increased interagency cooperation in the use of Federal medical resources. Accordingly, they generally support S. 266 as a means of achieving this goal. The Veterans Administration, however, raised one provision that causes them concern.

The provision would, "appear to make sharing arrangements operative upon agreement by facility directors . . ." The Veterans Administration expressed concern that this may not allow sufficient review at the Department level. With regard to this, the Committee feels that local administrators must be given as much discretion as is feasible in implementing sharing arrangements. These local administrators already have a great deal of contracting and purchasing authority—this autonomy is necessary to run their facilities efficiently to eliminate needless delays in approving these arrangements. The majority of sharing opportunities, those for sharing a piece of diagnostic equipment for instance, are the types of management and resource allocation proposals which would clearly be within the capability of local officials. The Committee recognizes that the magnitude of some interagency arrangements will require guidance from higher levels—this provision does not preclude this.

The General Accounting Office fully supports Bill S. 266.

SUMMARY OF LEGISLATION

Section 1.—Short Title.

Section 2.—Findings and Purposes.

This section contains the findings and purposes. The Congress finds that optimum coordination among Federal agencies, primarily the Veterans Administration and Department of Defense, in the use of Federal medical resources would minimize duplication and underutilization of medical facilities, and reduce costs to the Federal Government. Also, greater interagency sharing and planning may be achieved with having any detrimental effect on each agency's beneficiaries, and in many cases, would improve the quality of, and access to care available to Federal beneficiaries.

Statutory and regulatory restrictions have served as impediments to maximized interagency sharing and coordination. Also, there are not adequate incentives in the various direct health care systems to encourage the most efficient use of Federal facilities.

The purpose of this legislation is to provide incentives for maximized interagency sharing, remove the legal and administrative impediments to greater coordination by expanding the authority of the Veterans Administration and Department of Defense as health care providers, and encourage these providers to implement sharing where feasible.

Section 3.—Definitions

Section 4—Interagency medical care coordination

Joint duties for the implementation of this legislation are contained in this section.

Subsection (a) states that in order to establish policies for interagency sharing of their medical resources there is hereby established a Federal Interagency Sharing Committee composed of the Administrator of Veterans Affairs and the Secretary of Defense or their designees. The Sharing Committee is directed, notwithstanding any other Federal Law relating to interagency sharing of medical resources, to undertake the following duties:

> Assess the opportunities for interagency sharing of existing medical resources between the Veterans Administration and Department of Defense. The Committee feels it is important that these two agencies comprehensively assess each of their respective medical capabilities. Complete and accurate information is essential in considering the potential for sharing medical resources.
>
> Remain continuously apprised of the planning of any additional medical facilities or the acquisition of new medical equipment by either the Veterans Administration or the Department of Defense with regard to the impact of such plans on the opportunities for interagency sharing. The Commit-

> tee's purpose here is to encourage these Federal providers of direct health care to jointly, and on a systematic basis assess the potential for consolidating or sharing any planned medical capability which might reduce costs to the Federal government without adversely affecting the quality of medical care.
>
> Identify medical capabilities within their agencies, including support and administrative services, to identify sharing opportunities that will not adversely affect the quality of, or established priority of, care provided.
>
> Coordinate and prescribe uniform interagency policies and procedures designed to maximize the interagency sharing of their medical resources.
>
> Coordinate and prescribe uniform interagency policies and procedures for coordinated planning for future development of each agency's direct health care delivery system. It is specified that the agency heads be responsible for monitoring the implementation of such policies and procedures.
>
> With regard to all of the above duties, these agencies should consult, to the extent possible, with other Federal providers to encourage optimum coordination in the delivery of all Federal direct health care.

The Veterans Administration and Department of Defense operate over 300 hospitals. The other largest Federal provider, the Public Health Service maintains only 8. In view of this, the greatest potential for reducing costs and improving medical care remains with greater Veterans Administration and Department of Defense sharing and coordination, thus, this legislation focuses primarily on these two agencies.

Nevertheless, the Committee feels that in assisting capabilities, determining opportunities for sharing existing medical resources or planning for future development, and coordinating and prescribing uniform policies and procedures, that the Sharing Committee should consult on a regular and continuous basis with other Federal providers.

The Committee feels that consultation is most necessary where sharing is considered where Federal direct health care providers in addition to the Veterans Administration and Department of Defense have existing or planned medical resources.

Finally, it is recommended that in cases where Federal providers, other than the Veterans Administration and Department of Defense are included in Veterans Administration and Department of Defense sharing plans and arrangements, that such plans and arrangements be agreed to by all Federal providers involved.

Prescribe uniform guidelines, within 180 days of enactment of this Act, to the directors and commanding officers of health care facilities within the jurisdiction of the Veterans Administration and Department of Defense.

These guidelines shall provide for the following:

> Directors and commanding officers of health care facilities are to enter into interagency cooperation sharing arrangements whenever possible.

Any beneficiary eligible for direct health care in one agency may receive medical care at a providing facility of another agency.

Services to be shared may include any medical resource or medical support resource.

Medical resources to be shared shall be negotiated by the directors or commanding officers of these health care facilities. The purpose of this provision is to encourage free negotiation at the local hospital level. The Committee does not mean, however, to preclude the negotiation of interagency sharing at any level within the providing agencies.

The availability of direct health care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and shall not adversely affect the access to or quality of care of the providing agency's beneficiaries.

The rate for reimbursement for shared services is to be based on negotiated costs as agreed to by the directors or commanding officers of the participating health care facilities. Negotiated cost is the cost determined by local hospital officials to be an equitable and consistent charge for the services provided at those facilities.

Reimbursement is to be credited when received by the providing agency to the specific facility that provided the service. The Committee feels that this provision is the most important incentive for interagency sharing. Therefore, it is crucial to the success of these arrangements that the providing facility be reimbursed directly and promptly for services provided under sharing arrangements.

Federal health officials have expressed concern that funds received by a facility as reimbursement for services they have provided might be received too late, the last week of the fiscal year for instance, to be used to offset the expense of providing such services. Therefore, the Committee suggests that reimbursement be planned and budgeted as early as possible in the budget cycle.

Also, it is recommended that the agencies and OMB consider allowing reimbursed funds received late in the fiscal year to be allocated to the providing facility for the fiscal year following the year in which the funds were received.

In addition, the Committee recognizes that in many cases the imposition of rigid personnel ceiling seriously restricts implementation of interagency sharing arrangements. It is recommended that in situations where it is clearly demonstrated that personnel ceilings preclude cost-effective sharing arrangements that OMB and the agencies consider relief of such ceilings. Such relief could allow providing agencies to hire additional personnel from the proceeds of sharing agreements. Necessary funds should flow from the negotiated reimbursement agreements and additional personnel hired for sharing purposes should be approved by the Executive branch.

Sharing arrangements are to be operative upon agreement of the directors or commanding officers entering into such arrangements unless disapproved upon submission to each agency. The Committee feels that local administrators must be given as much discretion as is feasible in implementing sharing arrangements. These local administrators already have a great deal of contracting and purchasing authority—this autonomy is necessary to run their facilities efficiently and effectively. The majority of interagency sharing opportunities, those for sharing a piece of diagnostic equipment for instance, are the types of management and resource allocation proposals which would clearly be within the capability of local administrators.

The Committee recognizes that the magnitude of some interagency arrangements will require headquarters guidance. This provision does not preclude headquarters involvement in interagency sharing—it is merely intended to give the maximum feasible latitude at the local level.

Nothing in the Act shall be construed to preclude sharing of medical resources pursuant to any other law among all Federal direct health care providers.

Subsection (b) states that the joint responsibilities of the heads of these agencies under this Act are not intended to alter any single agency's responsibilities with regard to the provision of medical services provided by law.

The Sharing Committee is to report to Congress annually on their progress with regard to the duties mentioned above. The Committee suggests that this report also highlight the specific difficulties encountered in implementing this Act.

COMMITTEE ACTION

The Committee considered S. 266 during its mark-up on May 21, 1981. The bill was agreed to unanimously by a vote of 10–0. There were no amendments.

AYES—10	NOES—0
Senator Roth	
Senator Percy	
Senator Cohen	
Senator Durenberger	
Senator Mattingly	
Senator Rudman	
Senator Eagleton	
Senator Chiles	
Senator Sasser	
Senator Levin	

EVALUATION OF REGULATORY IMPACT

Paragraph 11(b)(1) of Rule XXVI requires each report accompanying a bill to evaluate the regulatory impact which would be incurred in carrying out the bill.

S. 266 requires that the Veterans Administration and Department of Defense establish policies and procedures for maximized interagency sharing of their medical resources. These policies and procedures are designed to remove much of the regulatory burden on local Federal hospital directors and commanding officers.

COST ESTIMATE

Since S. 266 is nearly identical to S. 2958, the Committee did not feel that it was necessary to obtain new cost estimates.

The Congressional Budget Office reported that the administrative costs of implementing S. 2958 are not expected to be significant. They said that this bill has the potential for effecting substantial long-range reductions in the medical care costs of both the Veterans Administration and the Department of Defense.

CHANGES IN EXISTING LAW

Paragraph 12 of Rule XXVI requires a notation of changes in existing law. Since this legislation does not amend any other law, it is free standing, there are no such changes in existing law.

APPENDIX C

II

Calendar No. 288

97TH CONGRESS
1ST SESSION

S. 266

[Report No. 97-137]
[Report No. 97-196]

To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources.

IN THE SENATE OF THE UNITED STATES

JANUARY 27 (legislative day, JANUARY 5), 1981

Mr. PERCY (for himself, Mr. COHEN, Mr. DURENBERGER, and Mr. PROXMIRE) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

JUNE 4 (legislative day, JULY 1), 1981

Ordered, that if and when reported, the bill be referred to the Committee on Veterans' Affairs for not to exceed forty-five days

JUNE 15 (legislative day, JUNE 1), 1981

Reported by Mr. ROTH, without amendment, and referred, pursuant to the order of June 4, 1981, to the Committee on Veterans' Affairs for not to exceed forty-five days

JULY 30 (legislative day, JULY 8), 1981

Ordered that the Committee on Veterans' Affairs have until not later than September 23, 1981, to report

SEPTEMBER 23, 1981

Ordered that the Committee on Veterans' Affairs have until not later than September 29, 1981, to report

SEPTEMBER 29 (legislative day, SEPTEMBER 9), 1981

Reported by Mr. SIMPSON, with an amendment and an amendment to the title

[Strike out all after the enacting clause and insert the part printed in italic]

A BILL

To establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, ~~That this Act may be cited as the "Federal Interagency Medical Resources Sharing and Coordination Act of 1981".~~

~~FINDINGS AND PURPOSES~~

~~SEC. 2. (a) The Congress finds that—~~

~~(1) coordination among Federal agencies in the use of Federal medical resources would minimize duplication and underutilization of Federal direct health care facilities, reduce costs, and enhance health care;~~

~~(2) optimum coordination between the Veterans' Administration and Department of Defense, the largest Federal providers of direct health care, would reduce health care costs and, in many cases, improve the quality of, and access to care available to Federal beneficiaries;~~

~~(3) greater interagency sharing of medical resources between the Veterans' Administration and the Department of Defense may be achieved without a detrimental effect on each agency's primary beneficiaries;~~

~~(4) currently there are not adequate incentives in the various Federal direct health care delivery systems to encourage maximum interagency use of Federal medical resources;~~

~~(5) the Veterans' Administration and the Department of Defense should, to the extent feasible within each agency's responsibilities, share medical resources and increase the coordination of medical care; and~~

~~(6) the establishment of an interagency committee will facilitate interagency sharing of medical resources between the Veterans' Administration and the Department of Defense.~~

~~(b) It is the purpose of this Act to (1) clarify and expand the authority of the Veterans' Administration and the Department of Defense as direct health care providers in order to facilitate Federal interagency sharing of medical care and medical care support resources and (2) establish an interagency committee to serve as a mechanism to encourage maximum interagency sharing of such resources.~~

~~DEFINITIONS~~

~~SEC. 3. As used in this Act, the term—~~

~~(1) "direct health care" means any health care provided to an eligible beneficiary in a facility operated by the United States Government, including inpatient~~

~~care and any type of outpatient treatment, testing, or examination;~~

~~(2) "beneficiary" means any individual who is entitled by law to direct health care furnished by the Veterans' Administration or the Department of Defense;~~

~~(3) "providing agency" means the Veterans' Administration or the Department of Defense;~~

~~(4) "primary beneficiary" means an individual who is specifically entitled by law to direct health care in the facilities of a particular providing agency;~~

~~(5) "negotiated cost" means the cost determined by local hospital officials on a medical service-by-service, hospital-by-hospital basis to be an equitable and consistent charge for the services provided; and~~

~~(6) "medical resource" means medical care and medical care support resources.~~

~~INTERAGENCY FEDERAL MEDICAL CARE COORDINATION~~

~~SEC. 4. (a) There is established a Federal Interagency Medical Resources Committee (hereafter in this Act referred to as the "Committee"). The Committee shall be composed of the Secretary of Defense and the Administrator of Veterans' Affairs or their designees. In order to establish policies applicable to the Veterans' Administration and the Department of Defense as Federal direct health care providers with~~

~~regard to interagency sharing of medical resources, the Committee shall, notwithstanding any other provision of Federal law relating to interagency sharing of medical resources, undertake the following:~~

~~(1) Assess the opportunities for interagency sharing of existing medical resources between the Veterans' Administration and the Department of Defense.~~

~~(2) Remain continuously apprised of the planning of any additional Veterans' Administration or Department of Defense medical facilities, including the location of new facilities and the acquisition of major new medical equipment, with regard to the impact of such plans on opportunities for interagency sharing.~~

~~(3) Review existing Veterans' Administration and Department of Defense direct health care capabilities, including support and administrative services, to identify sharing opportunities that will not adversely affect the quality of, or the established priority of, care provided.~~

~~(4) Prescribe policies and procedures designed to maximize the interagency sharing of the Veterans' Administration and the Department of Defense medical resources.~~

~~(5) Coordinate the establishment of uniform interagency health care policies and procedures for provid-~~

~~ing agencies and monitor the implementation of such policies and procedures, including policies and procedures for coordinated planning for future development of each agency's direct health care delivery system.~~

~~(6) Consult, when appropriate with regard to carrying out the matters described in paragraphs (1) through (5), with other Federal providers to encourage optimum coordination in the delivery of direct health care.~~

~~(7) Prescribe uniform guidelines, within one hundred and eighty days after the date of the enactment of this Act, to directors and commanding officers of health care facilities within the Veterans' Administration and the Department of Defense for the sharing of medical resources by such health care facilities. Such guidelines shall provide, consistent with the policies and procedures developed under this Act, for the following:~~

~~(A) The director or commanding officer of each health care facility within the jurisdiction of the Veterans' Administration and the Department of Defense shall, whenever possible, enter into interagency cooperative sharing arrangements with other health care facilities of such providing agencies. Under such arrangements, a beneficiary~~

~~eligible for direct health care in one agency's facility may receive medical care at a providing facility of the other agency.~~

~~(B) Services to be shared may include any medical resource.~~

~~(C) Medical resources to be shared shall be negotiated by the directors or commanding officers of the health care facilities entering into an arrangement.~~

~~(D) The availability of direct health care to beneficiaries of an agency other than the providing agency shall be on a referral basis, and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the quality of care and priority access for medical services of the providing agency's beneficiaries.~~

~~(E) Whenever a beneficiary receives medical services from a providing agency other than the particular providing agency for which such beneficiary is a primary beneficiary, such providing agency shall be reimbursed based on negotiated costs as agreed by the directors or commanding officers of the participating health care facilities.~~

~~(F) Reimbursement shall be credited when received by the providing agency to the specific facility that provided the medical service.~~

~~(G) Sharing arrangements shall be operative upon agreement of the directors or commanding officers entering into such arrangements unless disapproved upon submission to each agency.~~

~~(b) Nothing in this Act shall be construed to preclude sharing of medical resources among all Federal direct health care providers pursuant to any other law.~~

~~(c) The responsibilities of the Committee under this Act with regard to uniform direct health care shall not be construed to alter any providing agency's responsibilities with regard to the provision of medical services provided by law.~~

~~(d)(1) The Committee shall, within one year after the date of the enactment of this Act, prepare and transmit to the Congress a report, including such legislative recommendations as the Committee considers appropriate, with regard to—~~

~~(A) the guidelines prescribed pursuant to subsection (a)(6);~~

~~(B) the opportunities for interagency sharing as required in section 4(a)(1);~~

~~(C) the interagency sharing arrangements entered into by health care facilities of such providing agency;~~

~~(D) each providing agency's activities pursuant to cooperative interagency sharing arrangements;~~

~~(E) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;~~

~~(F) the progress of Federal interagency medical resource sharing;~~

~~(G) the interagency coordination of Federal health resources planning; and~~

~~(H) other major Federal activities to increase interagency sharing of Federal medical resources.~~

~~(2) Each year at the time the President transmits the Budget under section 201(a) of the Budget and Accounting Act, 1921, beginning with the year after the year in which the Committee submits its report under paragraph (1), the Committee shall prepare and transmit to the Committees on Appropriations of the Senate and the House of Representatives a report for the preceding year containing the information described in paragraph (1).~~

That this Act may be cited as the "Veterans' Administration and Department of Defense Health-Care Resources Sharing Act".

SEC. 2. (a) The Congress finds that—

(1) there are opportunities for greater coordination and sharing of the health-care resources of the Veter-

ans' Administration and the Department of Defense which, if achieved, would be beneficial to veterans, members of the Armed Forces on active duty, and other health-care beneficiaries of the Veterans' Administration and the Department of Defense, and which could result in reduced costs to the Government by minimizing duplication and underutilization of health-care resources;

(2) there are not adequate incentives to encourage such coordination and sharing of health-care resources; and

(3) such coordination and sharing of health-care resources may be achieved without a detrimental effect on each agency's primary beneficiaries.

(b) The Congress further finds that—

(1) there might be situations during a period of war or national emergency in which the Department of Defense would not have adequate health-care resources; and

(2) the Veterans' Administration has an organized health-care system which could be used to assist the Department of Defense in meeting the medical contingencies which might occur during a period of war or national emergency.

Sec. 3. (a) There is established an interagency committee to be known as the Veterans' Administration/Department of Defense Health-Care Resources Coordination Committee (hereinafter referred to as the "Committee").

(b) The Committee shall be composed of the Chief Medical Director of the Veterans' Administration (hereinafter in this section referred to as the "Chief Medical Director") and the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the "Assistant Secretary"), or their respective designees, and such other employees of the two agencies as they shall mutually designate.

(c) In order to promote the coordination of health-care services between the Veterans' Administration and the Department of Defense and to provide guidance to the two agencies in regard to the interagency sharing of health-care resources, the Committee shall on a continuing basis—

(1) review existing policies and practices in regard to the coordination and sharing of health-care resources (including administrative and support services) between the two agencies;

(2) identify and assess further opportunities for the coordination and sharing of health-care resources between the two agencies that will not adversely affect the quality of, or the established priorities for, care provided by either agency;

(3) develop and recommend to the Administrator of Veterans' Affairs and the Secretary of Defense changes in policies and procedures which would produce maximum feasible interagency coordination and sharing of health-care resources between the two agencies as authorized by title 38, United States Code;

(4) provide guidance for and monitor the implementation of activities designed to promote such coordination and sharing of health-care resources;

(5) monitor the plans of the two agencies to acquire additional health-care resources (including the location of new facilities and the acquisition of major equipment), and review the potential impact of such proposals on opportunities for such coordination and sharing; and

(6) develop, in consultation with such other agencies as the President may direct, a plan for the effective utilization of Veterans' Administration resources, as authorized in subsection (e) of section 5011 of such title (as added by section 4(a)(4) of this Act), to assist in meeting medical contingencies which might result from a period of war or national emergency.

(d) In carrying out the duties prescribed in this Act, the Assistant Secretary shall consult regularly with the surgeons general of the Army, Navy, and Air Force.

SEC. 4. (a) Section 5011 of title 38, United States Code, is amended—

(1) by amending the heading to read as follows:

"§ 5011. Sharing of Veterans' Administration and Department of Defense health-care resources";

(2) by inserting "(a)" before "The Administrator";

(3) by striking out "and material" and all that follows through "this title," and inserting in lieu thereof "material, and other resources as may be needed to operate such facilities properly, except that at no time shall the Administrator enter into any agreement which will result in a permanent reduction of Veterans' Administration beds below any minimum number prescribed by law"; and

(4) by adding at the end the following new subsections:

"(b) After considering the recommendations made under section 3(c)(3) of the Veterans' Administration and Department of Defense Health-Care Resources Sharing Act, the Administrator and the Secretary of Defense shall jointly establish guidelines for the sharing of health-care resources to the maximum extent feasible consistent with the health-care responsibilities of the Veterans' Administration and the Department of Defense under this title and title 10. Such guide-

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lines shall be established not later than nine months after the date of enactment of this subsection, and (notwithstanding any other provision of law) shall include provisions for the following:

"(1) The director or the commanding officer of each health-care facility under the jurisdiction of either of the two agencies shall, to the maximum extent feasible, appropriate, and consistent with such respective responsibilities, enter into sharing agreements with the head of each health-care facility of the other agency in the same geographic area under which those eligible beneficiaries of one agency who are identified in the agreement may be provided health care at the facility of the other agency.

"(2) Each such agreement shall explicitly identify the health-care resources to be shared, the health care to be provided, and the beneficiaries to be treated. Resources to be shared may include any health-care resource.

"(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis from the facility of the other agency and shall not (as determined by the heads of the facilities concerned) adversely affect the range of

services, quality of care, or priority for services provided to the primary beneficiaries of such providing agency.

"(4) Each such agreement shall be submitted on the same day to the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter referred to as the 'Assistant Secretary') and shall become an interagency agreement (A) on the forty-sixth day following receipt by such officials, unless earlier disapproved by either such official, or (B) if earlier approved by both such officials, on the date of such approval.

"(5) Each such agreement shall provide that the agency providing the health-care services will be reimbursed by the other agency for the cost of care and services provided. Such reimbursement shall be based upon a methodology, agreed upon by the Chief Medical Director and the Assistant Secretary, which provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and needs and the actual costs to the facility being reimbursed. Such reimbursements shall be credited to appropriations available to the facility which provided such care or services.

"(c) The Administrator and the Secretary of Defense shall, each year at the time the President's Budget is transmitted to Congress, jointly submit a report to Congress on the implementation of subsection (b) of this section during the fiscal year that ended during the previous calendar year. Each such report shall include information with regard to—

"(1) the guidelines and any revisions thereof prescribed pursuant to subsection (b) of this section;

"(2) the assessment of opportunities, identified under section 3(c)(2) of the Veterans' Administration and Department of Defense Health-Care Resources Sharing Act, for coordination and sharing of health-care resources between the two agencies;

"(3) the recommendations, made under section 3(c)(3) of such Act, for changes in policies and procedures in order to produce maximum feasible interagency coordination and sharing of such resources as authorized by this title;

"(4) a review of the interagency sharing agreements entered into by health-care facilities of the two agencies;

"(5) the activities of the two agencies under such agreements;

"(6) other interagency coordination, planning, and activities involving either agency directed toward

producing the maximum feasible efficient use of Federal health-care resources during the preceding fiscal year; and

"(7) such legislative recommendations as the Administrator and the Secretary of Defense consider appropriate to facilitate interagency sharing of health-care resources between and by the two agencies.

"(d) For the purposes of this section:

"(1) The term 'direct health care' means health care provided to a beneficiary in a facility operated by the Veterans' Administration or the Department of Defense.

"(2) The term 'beneficiary' means (A) a veteran or other person who is eligible under this title for health care in Veterans' Administration facilities, or (B) a member or former member of the Army, Navy, Air Force, or Marine Corps or other person who is eligible for medical and dental care under title 10.

"(3) The term 'providing agency' means the Veterans' Administration or the Department of Defense, as appropriate.

"(4) The term 'primary beneficiary' means (A) with respect to the Veterans' Administration a veteran or other person who is eligible under this title (other than by virtue of subsection (b) of this section) for

health care in Veterans' Administration facilities, and (B) with respect to the Department of Defense a member or former member of the Army, Navy, Air Force, or Marine Corps or other person who is eligible for medical and dental care under title 10.

"(5) The term 'health-care resource' means any health-care resource and any health-care support or administrative resource, including hospital care, medical services, and rehabilitative services as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 601 of this title.

"(e)(1) During a period of war declared by the Congress or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, notwithstanding any other provision of this title, the Administrator may (pursuant to regulations which the Administrator shall prescribe)—

"(A) give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, to the extent authorized by this subsection, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities; and

"(B) to the extent authorized by the President and subject to the availability of appropriations or reimbursements under paragraph (2)(B) of this subsection, contract with private facilities for the provision by such facilities of hospital care and medical services described in paragraph (2)(A) of this subsection during a period of war or national emergency as described in this paragraph.

"(2)(A) Hospital care and medical services referred to in paragraph (1)(B) of this subsection are—

"(i) hospital care or medical services authorized under this title for a veteran and necessary for the care or treatment of a condition for which the veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which the delay involved in furnishing such care or services at the Veterans' Administration facility concerned would, in the judgment of the Chief Medical Director pursuant to regulations prescribed by the Administrator, be likely to result in a significant deterioration of that condition; and

"(ii) hospital care for a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care under chapter 17 of this title, if the Chief Medical Director pursuant to regulations

prescribed by the Administrator, finds that the Veterans' Administration facility concerned is utilizing a substantial portion of its hospital care capability for the furnishing of priority care to members of the Armed Forces under paragraph (1) of this subsection.

"(B) The cost of any care or services provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense based on the cost of such care or services provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided such care or services.

"(3) Within ninety days after the declaration of a period of war or national emergency described in paragraph (1) of this subsection (or as soon after the end of such ninety-day period as is reasonably practicable), the Administrator shall submit to the committees a report on the allocation of facilities and personnel in order to provide priority hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. Thereafter, the Administrator shall report periodically to the committees regarding the extent to which, and the circumstances under which, the au-

thority to contract with private facilities provided in paragraph (1)(B) of this subsection is being used.".

(b) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5011. Sharing of Veterans' Administration and Department of Defense health-care resources.".

(c) Not later than one hundred and eighty days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall enter into an agreement with the Secretary of Defense under which the Administrator and the Secretary shall agree to pursue planning activities and to establish procedures and guidelines under which subsection (e) of section 5011 of title 38, United States Code (as added by subsection (a) of this section), may be carried out.

Amend the title so as to read: "A bill to foster greater coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense, and to amend title 38, United States Code, to authorize appropriate coordination and sharing of such health-care resources.".

APPENDIX D

Calendar No. 288

97TH CONGRESS
1st Session

SENATE

REPORT
No. 97-196

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE HEALTH-CARE RESOURCES SHARING ACT

SEPTEMBER 29 (legislative day, SEPTEMBER 9), 1981.—Ordered to be printed

Mr. SIMPSON, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany S. 266]

The Committee on Veterans' Affairs, to which was referred the bill (S. 266) to establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health care resources, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute, and an amendment to the title, and recommends that the bill, as amended, do pass.

COMMITTEE AMENDMENTS

The amendments are as follows:
Strike out all after the enacting clause as follows:

* * * * * * *

INTRODUCTION

The Veterans' Administration and the Department of Defense are the largest direct health-care providers in the United States. One means of assuring the effective and efficient use of Federal funds for the delivery of health services is to promote the coordination and sharing of the health-care resources between these two agencies. Such efforts should help counteract the rapidly increasing costs of health care in the Nation without adversely affecting the quality of care provided to Federal beneficiaries.

On January 27, 1981, Senator Charles H. Percy, the Chairman of the Subcommittee on Energy, Nuclear Proliferation, and Government Processes, introduced S. 266 to establish a Federal Interagency Medical Resources Committee to ensure the most efficient and effective use of Federal direct health-care resources. The bill was similar to S. 2958 (96th Congress) which was passed by the Senate on September 29, 1980. S. 266 would promote sharing of resources through such interagency committee functions as assessment of opportunities for sharing, the prescription and coordination of policies and procedures, and the establishment of specific guidelines. S. 266 was reported by the Committee on Governmental Affairs on June 15, 1981, and referred to the Committee on Veterans' Affairs for a period which was extended to September 29, 1981.

On June 9, 1981 Amendment No. 62 to S. 636 was introduced by the Committee's Ranking Minority Member, Senator Alan Cranston. Identical to H.R. 3502 as introduced in the House of Representatives, it would amend title 38, United States Code, to provide authority for the Veterans' Administration and the Department of Defense to engage in activities designed to promote the coordination and sharing of health resources. An interagency committee would maintain oversight of such opportunities and make appropriate recommendations to the heads of the two agencies. Beneficiaries would be limited to eligible veterans and eligible members or former members of the Army, Navy, Air Force or Marine Corps, thus excluding military dependents. It would also establish a new statutory mission for the Veterans' Administration so that it could assist the Department of Defense in the treatment of casualties resulting from the involvement of the Armed Forces during a period of war or national emergency. Such contingency authority would include an exemption from executive branch review of requests to Congress for relief from personnel ceilings and for appropriations to carry out emergency functions, as well as a procedure for relieving Veterans' Administration employees from military service obligations.

On June 17, 1981, Senator Frank H. Murkowski chaired a hearing of this Committee on the provisions of S. 266 and Amendment 62 to S. 636. The hearing opened with a statement by Senator Charles H. Percy, chairman of the Committee on Governmental Affairs. He endorsed S. 266 because of its potential to effect significant cost savings while enhancing the health care of veterans and other Federal beneficiaries. However, he had major concerns about two provisions in Amendment No. 62. It would prohibit the Veterans' Administration from treating military dependents under any conditions, whereas in earlier Senate hearings witnesses testified that some services could and are being shared without adverse effect. Senator Percy also objected to the proposal to establish standard rates for medical services since they have been a major disincentive in the past. He closed by endorsing the concept of having the Veterans' Administration serve as a medical backup to the Department of Defense in time of war.

Representatives of the General Accounting Office endorsed S. 266 as responsive to recommendations they have made to Congress over the past several years. The Federal Government would achieve savings by eliminating duplication, increasing utilization of facilities, and reducing reliance on non-Federal providers. At the same time, patient care would be enhanced by consolidating workloads and resources and increasing staff proficiency. In some cases access would be improved by providing services nearer to the homes of veterans. Among the sections of S. 266 which were explicitly endorsed were those providing broad sharing authority (including such ancillary support services as laundries), a nonrestrictive definition of "beneficiary," and establishment of negotiated costs on a local basis. GAO also endorsed the initiation of contingency planning to assure effective use of Federal resources should there be a need to care for battlefield casualties.

The Assistant Secretary of Defense (Health Affairs) endorsed the peacetime sharing promoted by S. 266 as an appropriate extension of the Defense Department's ongoing efforts to share medical resources. The Department had to defer taking a position on the role of the Veterans' Administration in time of war or national emergency pending a policy review of this and related issues by the Administration over the next few months. In the case of overseas combat, the current plan is to provide aeromedical evacuation to the United States and to use the Civilian-Military Contingency Hospital System as a backup. It is assumed that the combined hospital resources of the Veterans' Administration and the Defense Department would be insufficient to meet the demands of a conventional central European war. The hearing was closed for about fifteen minutes so that some of the contingency issues could be examined more thoroughly.

The Acting Administrator of Veterans' Affairs pointed to experience under the Economy Act and authorization for sharing of specialized medical resources under title 38 as evidence that the Veterans' Administration has been committed to the concept of sharing. The proposed legislation would be helpful in dealing with existing disincentives which have been barriers to more extensive efforts. However, from the point of view of the Veterans' Administration the mechanisms in Amendment 62 were perceived as more flexible or more appropriate than those in S. 266. Provisions in Amendment 62 endorsed by the VA included crediting reimbursements on the billing date rather than the date of receipt, opportunity for prior review of agreements by central office in order to manage system development, and not broadening the definition of "beneficiary" to include military dependents.

In regard to the contingency planning and sharing provisions of Amendment 62, the Acting Administrator reviewed existing policy which calls for interagency planning under Executive Order 11490, and pointed out that the Federal Emergency Management Agency "might be called upon to coordinate national efforts" in the event of an attack on the United States. He stated that the proposal to formally charge the VA with a combat casualty support mission has implications which would require an opportunity for review by the new Administrator in coordination with other agencies. However, the provision in Amendment 62 for expedited submission of relief from personnel ceilings or for appropriations was considered an unwarranted intrusion into the prerogatives of the executive branch.

The Federal Emergency Management Agency was able to endorse the concept of peacetime sharing embodied in S. 266, but was not able to take a formal position on contingency planning since the Administration will be reviewing the issue in the context of its national security implications during the next few months. However, the FEMA representative stated the agency's belief that "the VA has the potential capacity to expand beds under extreme emergency conditions in numbers which would more than likely meet all DOD needs." Objections were raised to the following provisions of Amendment No. 62: the expedited budget and personnel procedure, the report to be submitted within thirty days of a national emergency, and the relief of VA personnel from any military service obligation.

Public participation was provided by representatives of four organizations devoted to the interests of veterans, i.e., the Veterans of Foreign Wars of the United States, The American Legion, AMVETS, and the Disabled American Veterans. Each of them endorsed both the peacetime sharing and the contingency planning proposals as means of supporting the special relationship which exists between the Veterans' Administration and the Department of Defense. However, the VFW, AMVETS, and DAV explicitly rejected participation in either sharing or planning by components of the Department of Health and Human Services because of differences in policies and mission. The American Legion raised concerns about the need for a costing formula for use in determining reimbursements, the membership level of the interagency committee, and the possibility that OMB might deduct reimbursements from the appropriations to the participating hospitals. It was also suggested that Congress consider incorporation of a sunset provision. Support for the legislation by all of the groups was predicated on the requirement that the basic health-care missions of the two participating agencies would not be impaired in any way by their resource sharing activities.

Subsequently, an amendment was developed in the nature of a substitute which establishes a VA/DOD Health-Care Resources Coordination Committee in a free-standing portion of the bill while providing authority for both peacetime and wartime sharing of health-care resources through an amendment to title 38, United States Code. In response to Senator Percy's concerns, the substitute allows all eligible beneficiaries of one agency to be treated in the facilities of the other agency on a referral basis, and provides that reimbursement shall be based on local conditions and costs and be made to the facility providing the service. The proposed contingency provision for direct submission of personnel and appropriation requests to Congress without executive branch review and the mechanism for exemption of VA personnel from military service obligations were eliminated. Care was taken to assure that the basic health-care responsibilities of the two agencies would not be compromised by their participation in coordination and sharing activities. By a poll completed on September 21, 1981, the Committee unanimously voted to report S. 266 with an amendment in the nature of the substitute and a title amendment. S. 266 as reported consists of provisions derived, with modifications, from S. 266 and Amendment No. 62 to S. 636.

SUMMARY OF S. 266 AS REPORTED

The basic purpose of S. 266 as reported (hereinafter referred to as "the Committee bill") is to foster greater coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense in order to minimize duplication and underutilization of Federal direct health-care facilities, reduce costs, and enhance health care, as well as to establish the Veterans' Administration health-care system as the primary backup to the Department of Defense health-care system for treatment of combat casualties of the Armed Forces. This would be accomplished through establishment of an interagency committee to plan and coordinate such sharing, as well as by amendments to title 38, United States Code, which would provide authority for peacetime and contingency sharing and coordination of health-care resources between the two agencies.

Included in the Committee bill are provisions which would:

1. Establish a VA/DOD Health-Care Resources Coordination Committee composed of the Chief Medical Director of the VA and the Assistant Secretary of Defense for Health Affairs, or their designees, and other employees they designate.
2. Establish as functions (to promote the coordination and sharing of health-care services) of the interagency committee the review of existing policies and practices, the identification and assessment of further opportunities, the development and recommendation of changes in policies and practices, the provision of guidance to the agencies, the monitoring of implementation activities, the appraisal of resource planning by each agency, and the development of a plan for effective utilization of VA resources to assist in meeting medical contingencies which might result from a period of war or national emergency.
3. Provide that sharing agreements will not result in a permanent reduction of Veterans' Administration beds below the minimum number prescribed by law.
4. Provide within nine months of enactment for the joint establishment by the Administrator of Veterans' Affairs and the Secretary of Defense of guidelines for the interagency sharing of health-care resources. Such guidelines shall provide for sharing agreements by local administrators which permit the sharing of any health-care resource, the treatment of any eligible beneficiary of the other agency on a referral basis, the reimbursement to the providing facility for the costs of services provided at rates reflecting local conditions and actual costs, and a 45-day review period for each agency.
5. Provide for annual submission to Congress of a joint report by the Administrator of Veterans' Affairs and the Secretary of Defense which covers guidelines and their revisions,

the assessment of opportunities for coordination and sharing, recommendations for policy and legislative changes, a review of sharing agreements, activities of the two agencies under such agreements, and other interagency activities directed toward producing the maximum feasible efficient use of Federal health-care resources.

6. Provide during a period of war or national emergency for the establishment of a higher priority to the furnishing of hospital care, nursing home care, medical services, and dental services to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

7. Provide during a period of war or national emergency for the President to authorize the Administrator of Veterans' Affairs to contract with private facilities for the provision of hospital care and medical services to specific groups of eligible veterans with urgent health-care needs which might otherwise not be met in VA facilities.

8. Provide that within 90 days after the declaration of war or a period of national emergency the Administrator of Veterans' Affairs shall submit to the committees a report on implementation of the plan for the allocation of facilities and personnel to provide priority health care to members of the Armed Forces on active duty, and that the Administrator shall keep the committees informed of the use of the contract authority provided.

9. Provide that within 180 days of enactment of this legislation, the Administrator shall enter into an agreement with the Secretary of Defense under which they shall agree to pursue planning activities and to establish procedures and guidelines under which the contingency provisions may be implemented.

DISCUSSION

The Need for Greater Coordination and Sharing of Health-Care Resources

Over the past decade Congress has been concerned about the rapidly increasing cost of health care. In order to minimize the role of duplication or underutilization of health-care resources, various authorizations have been given to Federal agencies to share their capabilities and the private sector has been directed to coordinate and plan the use of health-care resources through the mechanisms created by the National Health Planning and Resources Development Act of 1974.

As part of its efforts to monitor such activities, the General Accounting Office (GAO) conducted a series of studies looking at inefficiencies in the delivery of health services. On June 14, 1978, the GAO issues a report entitled, "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." This study was based on headquarters interviews and field studies at fifty facilities of the VA, DOD, and HEW. On the basis of this review, GAO recommended that Congress enact legislation to establish a greatly expanded and cost-effective interagency sharing programm which should:

—Establish a Federal policy that directs interagency sharing when appropriate.

—Authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected.

—Eliminate all restrictions on the types of medical services which can be shared.

—Authorize Federal field hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government.

—Authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner.

—Establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources.

—Authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred.

—Assign to the Office of Management and Budget the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

S. 266 is designed to establish the legislative mandate for coordination and sharing of health-care resources between the VA and DOD when it is beneficial to both agencies. It promotes such activities designed to enhance the efficiency and quality of health-service delivery by the two agencies while removing perceived barriers and disincentives.

Establishment of an Interagency Committee To Promote the Coordination and Sharing of Health-Care Resources

In order to establish a focal point of accountability for the promotion of interagency activities directed toward the coordination and sharing of health-care resources, this Act establishes the Veterans' Administration/Department of Defense Health-Care Resources Coordination Committee. Responsibility for the establishment and operation of this committee is vested in the chief medical officers of the two agencies. They may jointly chair the committee or designate officials to serve in their behalf. Since there are specific tasks, such as analyses and reports, to be undertaken, it is assumed that agency employees will be assigned to work on and with the interagency committee.

There is nothing in the legislation which would preclude the use of existing mechanisms to perform the specified functions, as long as accountability is retained by the chief medical officers. For example, the Veterans' Administration, Department of Defense, and Public Health Service have formed a Federal Health Resource Sharing Committee, and there are VA and DOD committees that operate in conjunction with the Federal Emergency Management Agency (FEMA). To the extent that such groups which have been formed on an administrative basis engage in similar or identical tasks, there should not be a duplication of effort.

The specified functions call for establishment of a planning process whereby the two agencies review the current status of coordination and sharing, identify and assess further opportunities, and then develop goals with specific objectives for submission to the directors of their respective agencies. Once the Administrator of Veterans' Affairs and the Secretary of Defense issue guidelines for the sharing of health-care resources, the interagency committee shall continue to provide guidance and shall monitor the implementation of activities designed to promote such coordination and sharing. As part of the ongoing nature of the planning process, the interagency committee shall not only identify further improvements which can be made on the basis of experience with the program, but shall also keep informed of resource changes anticipated by each of the agencies and their potential impacts on coordination and sharing. Such changes specifically include the addition of new facilities and the acquisition of major equipment, but consideration should also be given to other changes such as those involving personnel utilization and management systems.

The Act also provides special authorities which may be invoked during a period of war or national emergency involving armed conflict. Although the planning for medical contingencies in such situations has a different emphasis than peacetime coordination and sharing, both wartime and peacetime efforts should strive for maximum efficient use of Federal resources. Furthermore, the GAO has pointed out in a report issued June 26, 1980, that the experience gained in peacetime coordination and sharing can form an experience base for contingency situations. Therefore, the interagency committee is also charged with developing a plan for the effective utilization of Veterans' Administration resources, as authorized in this Act, to assist in meeting medical contingencies which might result from a period of war or national emergency.

It is recognized that the President from time to time issues Executive orders establishing procedures to be followed during such emergency periods. The contingency planning is designed to assure that preparation is made for effective use of the special authorities in this Act at such time as they might be invoked by the President or Congress. Such contingency planning shall be done in consultation with such other agencies as the President may direct, such as FEMA and the Department of Health and Human Services.

In order to assure appropriate participation of all the Armed Forces in planning and implementation directed toward maximizing coordinating and sharing, the Assistant Secretary of Defense for Health Affairs shall consult regularly with the surgeons general of the Army, Navy, and Air Force.

Amendment of Title 38, United States Code

Since the Act clarifies and expands the authority of the Administrator of Veterans' Affairs in regard to the coordination and sharing of health-care resources, it is necessary to amend section 5011 of title 38, United States Code. The existing section would become subsection (a), and would be amended to eliminate the existing authority for the mutual transfer between the two agencies without reimbursement of facilities, supplies, equipment, or material needed and proper for the care of veterans. This does not mean that such transfers are prohibited, but that they are to take place through sharing agreements as created herein.

The new subsection (a) would be further amended to require that the Administrator not enter into any agreement which would result in a permanent reduction of Veterans' Administration beds below the minimum number prescribed by law.

New subsections (b) through (d) would establish a legislative mandate for interagency sharing between the Veterans' Administration and the Department of Defense when it is mutually beneficial. They do not alter the autonomy and separate statutory responsibilities of the two agencies, nor alter their existing missions and management authority.

Establishment of Guidelines for the Sharing of Health-Care Resources

The Administrator of Veterans' Affairs and the Secretary of Defense, after consideration of the recommendations developed by the VA/DOD Health-Care Resources Coordination Committee, are to establish within nine months guidelines for the sharing of health-care resources. Although this legislation is designed to foster such sharing to the maximum extent feasible, it is not meant to infringe upon the responsibilities of the VA and DOD under titles 38 and 10. Nor is it meant to alter or preclude the continued use of other authorities for coordination and sharing (such as 31 U.S.C. § 686, 10 U.S.C. § 1074(b), or 38 U.S.C. § 616 and § 5053).

The guidelines shall provide that the director or commanding officer of each health-care facility shall, to the maximum extent feasible, appropriate, and consistent with their responsibilities, enter into sharing agreements. The purpose of this provision is to encourage free negotiation at the local facility level. It does not preclude the negotiation of interagency sharing at any other level within the providing agencies.

Any health-care resources may be shared including support and administrative services as long as they are clearly identified in the sharing agreements. Likewise, any eligible beneficiaries of one agency may receive services from a facility of the other agency as long as the services are explicitly identified, are on a referral basis, and do not adversely affect the services provided to the primary beneficiaries of the providing agency. Although the Veterans' Administration is opposed to including military dependents among eligible recipients of shared services, this Committee believes that there are adequate safeguards in the new provisions to protect primary beneficiaries and that local administrators must be given as much discretion as is feasible in the implementation of sharing agreements.

Local administrators already have considerable contracting and purchasing authority. The majority of interagency sharing opportunities are the types of management and resource allocation proposals which would clearly be within their capabilities. However, in order to support agencywide planning and coordination it is appropriate for the chief medical officers of the two agencies to have a 45-day period within which to review all sharing agreements. They may jointly approve or individually disapprove such agreements on an earlier date, but if no action is taken by the end of the review period, the sharing agreements will automatically become effective on the 46th day after submission (or on the effective date specified in the agreement as approved). Failure to conform to the guidelines presumably would be the major basis for disapproval, though the chief medical officers probably would also consider the relationship of sharing agreements to systemwide health resource allocations.

One of the previous disincentives to sharing has been the application of standard OMB reimbursement rates which must be charged even when the services may be obtained for less through private contracting or are of negligible cost to the providing facility. The guidelines would assure that the providing facility be reimbursed for the cost of services on the basis of local conditions and needs and the actual costs to the facility being reimbursed. It is assumed that the two agencies will establish accounting procedures with adequate flexibility so that reimbursements are not lost due to the timing of funds availability in relation to the budget cycle.

So that Congress may monitor the program for sharing healthcare resources, the Administrator and the Secretary of Defense shall submit an annual report addressing the development, modification, and implementation of the guidelines for such sharing. The joint report is also to include a review of other interagency coordination, planning, and activities involving either agency directed toward producing the maximum feasible efficient use of Federal health-care resources, as well as any legislative recommendations to further facilitate sharing of health-care resources between and by the two agencies.

Contingency Authority for Periods of War or National Emergency

The Department of Defense has indicated that there could be combat situations in which they would not have the capacity to meet the demands for hospital care or casualties. To correct this deficiency, DOD is establishing voluntary agreements with civilian hospitals across the country to provide backup through what is called the Civilian-Military Contingency Hospital System.

The GAO has reviewed the contingency planning for combat casualties and issued a report on June 26, 1980, entitled, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System." It found that there are serious inadequacies in the existing contingency plans and their reliance on civilian hospitals. Efforts to involve the VA have been limited, in part because of questions about the legislative authority of the VA to treat combat casualties.

GAO has recommended that Congress enact legislation which provides that both DOD and VA fully participate in Federal medical planning for and care of returning wartime casualties. They state that such legislation should:

—Give VA the mission of providing direct medical support to DOD for treating battlefield casualties.

—Place battlefield casualties above veterans with non-service-connected, nonemergency conditions in VA's priority for care.

—Remove numerous obstacles to interagency sharing, as GAO previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system.

Delay in expanding the VA's mission to incorporate the planning for and treatment of combat casualties could result in unnecessary confusion during mobilization as well as underuse of the VA's medical capabilities.

The VA as the major Federal direct health care system should have a principal role as a contingency backup to the Department of Defense, particularly in view of the close association of its mission with the defense of the nation. This legislation would provide appropriate contingency authority to the Administrator which could be used only during a period of war or a period of national emergency involving the use of the Armed Forces in armed conflict.

A higher priority would be established for the furnishing of health-care services to active duty members of the Armed Forces than to any other eligible group with the exception of veterans with service-connected disabilities. The DOD is to reimburse the VA for such services, and the funds received are to be credited to each facility providing the services.

During such contingency conditions, VA facilities providing backup services to DOD might be unable to fulfill the urgent needs of veterans because of utilization by members of the Armed Forces. This legislation provides that the President may authorize the Administrator to contract with private facilities for the provision of hospital care and medical services to two classes of veterans eligible for health care. Contract services could be provided to a veteran already receiving medical services from the VA in any case in which delay in providing care would likely result in deterioration of the veteran's condition. Such services could also be provided to a veteran eligible for care or services in a medical emergency which poses a serious threat to the life of such veteran when the VA facility concerned is using a substantial portion of its capacity for the treatment of active duty members of the Armed Forces. These two situations require a judgment or finding by the Chief Medical Director. Such authority may be delegated under regulations associated with the contingency plans for decentralized operations under emergency conditions.

These new authorities should provide the VA with the flexibility to respond to the military medical needs of DOD while attending the the urgent health-care requirements of eligible veterans. The Secretary of Defense and the Administrator of Veterans' Affairs shall, within 180 days of enactment of this legislation, enter into an agreement to pursue planning activities and to establish procedures and guidelines for implementation of the contingency authorities created in subsection (e). So that Congress may monitor the implementation of these provisions, the Act calls for specific reports on the provision of priority care to members of the Armed Forces and the use of contract services.

COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., September 22, 1981.

Hon. ALAN K. SIMPSON,
Chairman, Committee on Veterans' Affairs, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed S. 266, the Veterans Administration and Department of Defense Health-Care Resources Sharing Act, as ordered reported by the Senate Committee on Veterans' Affairs, September 21, 1981.

This bill would direct the Administrator of Veterans Affairs and the Secretary of Defense to establish an interagency committee to study the possible opportunities for the sharing of the medical resources of their agencies and to recommend policies and procedures to maximize such sharing. While this bill could eventually result in savings to the federal government through the coordination and sharing of these medical resources, CBO is unable to estimate the magnitude of such savings without knowledge of the new policies and procedures that would ultimately be established.

Sincerely,

ALICE M. RIVLIN,
Director.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the Committee bill. The results of that evaluation are described below.

The Committee bill would establish a VA/DOD Health-Care Resources Coordination Committee to serve planning and advisory functions, and would amend title 38, United States Code, to provide authority for the sharing of health-care resources between the VA and DOD, for the establishment of contingency arrangements for the VA to serve as the principal back-up to DOD health-care facilities during a period of war or national emergency involving the Armed Forces in armed combat, and to authorize the VA to provide contract health-care for certain veterans during such a period of war or national emergency.

A. *Estimate of the numbers of individuals and businesses who would be regulated and a determination of the groups and classes of such individuals and businesses.*—The Committee bill would result in no regulation of individuals or businesses.

B. *Determination of the economic impact of such regulations on individuals, consumers and businesses affected.*—Since, as noted above, there would be no such regulations, there would be no resulting economic impact.

C. *Determination of the impact on the personal privacy of the individual affected.*—To the extent that beneficiaries of one agency would receive health-care services from the other agency, their medical records would be made available to the other agency for the purposes of providing the care involved. This should not significantly increase the impact on the personal privacy of participants since medical records are provided safeguards by both agencies.

D. *Determination of the amount of additional paperwork that will result from regulations to be promulgated under the bill.*—It is anticipated that the guidelines for sharing health-care resources which are to be promulgated by the Administrator and the Secretary of Defense will lead to the execution of numerous agreements designed to improve the efficiency of Government operations. Under the Committee bill, proposed agreements must be submitted for approval to the VA's Chief Medical Director and the Assistant Secretary of Defense for Health Affairs. It is not possible to predict with any accuracy the number of agreements that would be proposed.

RECORD OF VOTES CAST IN COMMITTEE

In connection with paragraph 7 of rule XXVI of the Standing Rules of the Senate, and in accord with a procedure agreed upon unanimously by the Members of the Committee on Veterans' Affairs, announcement is made that the Members of the Committee unanimously voted by poll, completed on September 21, 1981, to report favorably on S. 266, with an amendment in the nature of a substitute and an amendment to the title.

SECTION-BY-SECTION ANALYSIS OF S. 266 AS REPORTED

Section 1

Would provide that the Committee bill may be cited as the "Veterans' Administration and Department of Defense Health-Care Resources Sharing Act".

Section 2

Would state Congressional findings with respect to certain relationships between Veterans' Administration and Department of Defense health-care resources.

Subsection (a) of section 2 would state Congressional findings with reference to these relationships in terms of the coordination and sharing of the health-care resources of the two agencies, as follows:

(1) That there are, at present, opportunities for greater coordination and sharing of the health-care resources of the two agencies and that achieving greater coordination and sharing would be beneficial to the individuals eligible for care from the two agencies and could, at the same time, reduce the overall total cost to the Government of providing health care through the two agencies by minimizing the duplication and underutilization of the two agencies' health-care resources.

(2) That, at present, the incentives to encourage greater coordination and sharing of health-care resources between the two agencies are not adequate. In this regard, the Committee notes that, despite existing authority to share health-care resources, both pursuant to the Economy Act (31 U.S.C. 686) and various specific provisions in titles 10 and 38, other factors discourage greater sharing between the two agencies.

(3) That greater coordination and sharing of health-care resources between the two agencies could be achieved without having a detrimental effect on each agency's primary beneficiaries.

Subsection (b) of section 2 would state Congressional findings with reference to the relationships between the two agencies' health-care resources during a period of war or national emergency, as follows:

(1) That, during a period of war or national emergency, there might be situations in which the health-care resources of the Department of Defense would not be adequate to treat all of the members of the Armed Forces wounded or injured during the war or national emergency.

(2) That the VA has an organized health-care system that could serve as a backup to the health-care resources of the Department of Defense in meeting the medical contingencies that might occur during time of war or national emergency.

Section 3

Would establish an interagency committee to be known as the Veterans' Administration/Department of Defense Health-Care Resources Coordination Committee ("VA/DOD Committee") to promote the coordination of health-care services between the VA and the Department of Defense and to provide guidance to the two agencies regarding the sharing of the health-care resources of the two agencies. The Committee intends the establishment of this Committee to be concrete evidence of the intention of Congress to promote greater coordination and sharing of health-care resources between the two agencies and for this Committee to serve the important function of providing guidance to the two agencies on ways to achieve greater coordination and sharing.

Subsection (a) of section 3 would establish the VA/DOD Committee.

Subsection (b) of section 3 would provide that the VA/DOD Committee membership is to consist of the VA Chief Medical Director ("Chief Medical Director") and the Assistant Secretary of Defense for Health Affairs ("Assistant Secretary"), or their respective designees, together with other employees of the two agencies that the Chief Medical Director and the Assistant Secretary mutually designate to serve on that committee.

Subsection (c) section 3 would prescribe specific actions that the VA/DOD Committee would be required to undertake, on a continuing basis, so as to promote the coordination of health-care services between the two agencies and to provide guidance to the two agencies on the sharing of health-care resources between them.

Clause (1) of subsection (c) of section 3 would direct the VA/DOD Committee to review current policies and practices relating to the two agencies regarding the coordination and sharing of health-care resources, including administrative and support services, between the two agencies. The Committee intends that this review include not only the practice and policies of each of the two agencies but also any government-wide practices or policies that affect the sharing of resources betweeen the agencies.

Clause (2) of subsection (c) of section 3 would direct the VA/DOD Committee to identify and assess opportunities for the coordination and sharing of health-care resources between the two agencies that would not have an adverse effect on the quality of health care provided by either agency or either agency's priorities for care established under current law, for that agency's primary beneficiaries (defined in new subsection (d)(4) of section 5011 of title 38 as proposed to be added by section 4(a) of this bill). In this regard, the Committee intends a thoroughgoing review aimed at the discovery and evaluation of new opportunities as well as the analysis of those that are already known and might effectively be enlarged.

Clause (3) of subsection (c) of section 3 would direct the VA/DOD Committee to develop proposed changes in the policies and procedures of the two agencies in order to produce the maximum feasible coordination and sharing of health-care resources between the two agencies and to recommend these proposed changes to heads of the two agencies for their review and action as authorized by provisions of title 38, United States Code (including present section 5011 of title 38 with the amendments proposed to be made by section 4 or this bill).

Clause (4) of subsection (c) of section 3 would direct the VA/DOD Committee to provide guidance for and monitor the implementation of the two agencies' activities designed to promote the maximum feasible coordination and sharing of health-care resources between the two agencies. Through this activity, the Committee intends the VA/DOD Committee to serve an important oversight function, becoming a central repository for data relating to the extent of the coordination and sharing of health-care resources between the two agencies.

Clause (5) of subsection (c) of section 3 would direct the VA/DOD Committee to monitor the two agencies' plans to construct or acquire additions to either agency's health-care resources, including the proposed location of new facilities and the proposed acquisition of major equipment, such as computed axial tomography (CAT) scanners, and to review the coordination and sharing opportunities that would result from such planned additions. The Committee expects that these VA/DOD Committee activities would result in more carefully coordinated expenditures of funds by the two agencies for major additions to their health-care resources.

Clause (6) of subsection (c) of section 3 would direct the VA/DOD Committee, in consultation with such other agencies as the President may direct (such as the Federal Emergency Management Agency, if and to the extent appropriate) to develop a plan for the effective utilization, as authorized by new subsection (e) of section 5011 of title 38, United States Code (as proposed to be added by section 4(a) of this bill), of VA health-care resources as a backup to the Department of Defense in time of war or national emergency involving the use of the Armed Forces. The plan developed by the VA/DOD Committee would be submitted to the Administrator of Veterans' Affairs and the Secretary of Defense in order to assist them in carrying out their responsibilities under such new subsection (e) of section 5011.

Subsection (d) of section 3 would require the Assistant Secretary, in carrying out the duties prescribed in this measure (including those in the amendments to title 38 made by section 4 of this bill), to consult regularly with the surgeons general of the Army, Navy, and Air Force. The Committee expects that these consultations would ensure that the needs and views of the various services are recognized and addressed in overall VA/DOD sharing and coordination.

Section 4

Would amend present section 5011 of title 38, United States Code, relating to agreements between the Administrator and the secretaries of the Army, Navy, and Air Force for the sharing of certain health-care resources, to establish express authority, requirements, and procedures with respect to the sharing of health-care resources between the VA and the Department of Defense.

Clause (1) of subsection (a) of section 4 would amend the heading of present section 5011 of title 38 to read "Sharing of Veterans' Administration and Department of Defense health-care resources" to reflect more accurately the provisions of that section as proposed to be amended by clauses (2), (3), and (4) of this subsection.

Clause (2) of Subsection (a) of section 4 would redesignate the existing provisions of present section 5011 of title 38 as subsection (a) of that section.

Clause (3) of Subsection (a) of section 4 would further amend present section 5011 of title 38 (redesignated as subsection (a) by clause (2) of this subsection) to clarify that the agreements involving the mutual use or exchange of use of health-care capacity which the Administrator and the Secretaries of the Army, Navy, and the Air Force are authorized to enter into may include agreements for the use or exchange of use of any health-care resources (as that term would be defined, for purposes of section 5011, in new subsection (d) of that section as proposed to be added by clause (4) of this subsection, including health-care personnel as well as material items; to delete the authority in current law for the transfer of facilities, supplies, equipment, or material without reimbursement of appropriations in order to ensure that all such activity will take place pursuant to sharing agreements entered into pursuant to new subsection (b) of section 5011 as proposed to be added by clause (4) of this subsection; and to clarify that the Administrator may not enter into any agreement that would result in a permanent reduction of total VA beds below any minimum number of such beds prescribed by law. Present section 5010(a)(1) provides that "[t]he Administrator, subject to the approval of the President, is authorized to establish and operate not less than 125,000 hospital beds in medical facilities over which the Administrator has direct jurisdiction for the care and treatment of eligible veterans." The clarification regarding the minimum number of beds reflects the Committee's intent that the new emphasis placed on interagency sharing by this bill lead to the maximum feasible and appropriate use of the VA's health-care resources without any adverse effect on the VA's capacity to provide care to eligible veterans.

Clause (4) of Subsection (a) of section 4 would further amend present section 5011 of title 38 by adding four new subsections, as follows:

New subsection (b): Would require the Administrator and the Secretary of Defense, after reviewing the recommendations of the VA/DOD Committee, proposed to be established by section 3 of this bill, and not later than 9 months after the date of enactment of this subsection, jointly to establish guidelines that would result in the two agencies sharing health-care resources to the maximum extent feasible consistent with VA and DOD health-care responsibilities under provisions of law other than this section. New subsection (b) would specify, in six numbered paragraphs, provisions that would be required to be included in the joint guidelines, as follows:

Paragraph (1) of new subsection (b): Would require that the guidelines direct the head of each health-care facility under the jurisdiction of the VA or the Department of Defense, to the maximum extent feasible, appropriate, and consistent with each agency's health-care responsibilities under law, to enter into sharing agreements with the heads of health-care facilities of the other agency in the same geographic area and that, under such an agreement, individuals who are eligible for care in the facility of one agency and identified in the agreement, would be eligible for care in the facility of the other agency. This would include Defense Department beneficiaries who are dependents of members or former members of the Army, Navy, or Air Force, but only to the extent that the VA specifically agreed to their inclusion in a particular sharing arrangement. This provision is intended to help promote the maximum desirable degree of sharing of health-care facilities on the local level while ensuring that local facility heads enter sharing agreements only to the extent that those agreements can be carried out without having a detrimental impact on their ability to provide care to their primary beneficiaries under current law. As to the VA under title 38, the term "primary beneficiary" includes, for hospital or nursing home care in VA facilities under section 610, veterans who have or were discharged because of service-connected disabilities, veterans who are former prisoners of war, veterans over the age of 65, and veterans who are unable to defray the cost of their care (including, by virtue of section 622(3), any veteran in receipt of VA pension). With respect to direct VA outpatient care under section 612, the term "primary beneficiary" includes various categories of veterans for certain categories of medical treatment for service-connected and non-service-connected disabilities, as follows:

Categories of veterans	Type of disability	Outpatient medical treatment for which eligible
1. Veterans with service-connected disabilities	Any service-connected disability	Comprehensive (for the service-connected disability).
2. Veterans who (a) have service-connected disabilities rated 50-percent-or-more disabling, (b) are veterans of the Spanish-American War or World War I, (c) are former prisoners of war, or (d) are in need of regular aid and attendance or are housebound.	Any disability	Comprehensive.
3. Veterans (a) who are eligible for hospital care (by virtue of inability to defray the costs of the care involved) and (b) (1) whose service-connected disabilities are rated less than 50-percent disabling, or (2) have no compensable service-connected disabilities.	Any disability	Prehospital and posthospital care, and care that would obviate the need for hospitalization.

The term would also include dependents or survivors of certain veterans under certain limited circumstances pursuant to section 613 of title 38.

As to the Department of Defense, under title 10, the term "primary beneficiary" includes members and certain former members of the Army, Navy, or Air Force, and dependents, as that term is defined in section 1072 of title 10, of such members, under the circumstances prescribed in section 1076 of such title for the care and services specified in section 1077 of such title, which include inpatient and oupatient care.

Paragraph (2) of new subsection (b).—Would require that each sharing agreement entered into by local facility heads state explicitly the health-care resources to be shared, which could include support and administrative services, the health care to be provided, and the beneficiaries to be treated.

Paragraph (3) of new subsection (b).—Would require that each sharing agreement ensure that the identified beneficiaries of one agency would have access to the health-care facilities of the other agency under the agreement strictly on a referral basis and that the treatment of the beneficiaries of the other agency would not interfere with the range of services, quality of care, or priority for services provided to the primary beneficiaries of the agency providing the care. The head of each providing facility would have the responsibility for determining that the provision of care to the beneficiaries of the other agency would not have such an adverse impact.

Paragraph (4) of new subsection (b).—Would require that each proposed sharing agreement entered into by local facility heads, in order to become effective as an interagency agreement, be submitted to the Chief Medical Director and the Assistant Secretary. After both of these officials have received a proposed agreement, they would have 45 days within which to act on it. During that period, either such official could disapprove the agreement (and thereby nullify it) or both could approve it (at which point, it would become an interagency agreement). If there were no action (or if only one gave approval) within 45 days following the receipt of a proposed agreement, it would become an interagency agreement on the 46th day following receipt. Thus, the Committee intends that local facility directors have significant opportunity to initate and shape sharing agreements subject, however, to a measure of centralized control over such agreements maintained through the power given to the Chief Medical Director and Assistant Secretary to veto an agreement.

Paragraph (5) of new subsection (b).—Would require that the agency providing services pursuant to an interagency sharing agreement be reimbursed by the other agency. The reimbursement would be based on a methodology, to be agreed to by the Chief Medical Director and the Assistant Secretary, that would provide appropriation flexibility to the heads of the local facilities involved to take into account local conditions and needs as well as the actual cost of the service provided. This provision for crediting all reimbursements to appropriations available to the facility that provided the care would remove the existing disincentive to sharing between individual facilities that results from the requirement under current law that reimbursement for care provided to beneficiaries of another agency be deposited in a centralized account.

New subsection (c).—Would require the Administrator and the Secretary of Defense to submit an annual joint report to the Congress, at the same time the President's annual budget is sent to the Congress pursuant to section 201(a) of the Budget and Accounting Act, 1921 (31 U.S.C. 11(a)), with respect to the implementation during the most recent fiscal year, of new subsection (b) of section 5011 of title 38 (as proposed to be added by this clause). This new subsection would require that each annual report include information with regard to (1) the guidelines (including any changes thereto) relating to sharing that are prescribed pursuant to new subsection (b) of present section 5011 (as proposed to be added by this clause); (2) the assessment of opportunities for coordination and sharing of health-care resources identified by the VA/DOD Committee pursuant to section 3(c)(2) of the bill; (3) the recommendations made by the VA/DOD Committee, pursuant to section 3(c) (3) of the bill, for changes in policies and procedures of the two agencies in order to produce the maximum feasible level of interagency coordination and sharing of health-care resources; (4) a review of all interagency sharing agreements that have been entered into by local health-care facilities of the two agencies; (5) the activities of the two agencies under those agreements (in this connection the Committee expects the reports to describe, among other things, the types of services shared, the number of beneficiaries of one agency served by health-care facilities of the other, and other pertinent information that would indicate the extent of sharing activity undertaken by the two agencies); (6) other interagency coordination, planning, and activities involving either agency directed toward producing the maximum feasible efficient use of Federal health-care resources during the fiscal year that is the subject of each such report (in this connection, the Committee expects the report to include information describing, in addition to VA/DOD interagency activities, activities other than those under this bill, involving the VA or the Department of Defense and other agencies); and (7) recommendations for legislative action to facilitate interagency sharing of health-care resources between and by the two agencies.

New subsection (d).—Would define, in five numbered paragraphs, terms used in this section, as follows:

Paragraph (1) of new subsection (d).—Would define the term "direct health care" to mean care provided in a facility operated by the VA or the Department of Defense. This definition would not include care provided by either agency on a fee-for-service or other contractual basis. This term is used in new subsection (b) of section 5011 (as proposed to be added by clause (4) of this subsection) to describe the health-care services that the facility of one agency may provide under a sharing agreement to the beneficiaries of the other agency. By virtue of this definition, therefore, sharing agreements may not provide for a facility of one agency to furnish care to a beneficiary of the other agency under a fee-for-service or other contractual arrangement with a third agency or a private individual or agency.

Paragraph (2) of new subsection (d).—Would define the term "beneficiary" to mean (A) a veteran or other person (dependents of veterans under certain limited circumstances pursuant to section 613 of title 38) eligible for health care under title 38, or (B) a member, or former member of the Army, Navy, Air Force, or Marine Corps or other persons (dependents of such members or former members under the conditions prescribed in section 1076 of title 10 and for the care specified in section 1077 of such title) eligible for medical or dental care under title 10.

Paragraph (3) of new subsection (d).—Would define the term "providing agency" to mean either the VA or the Department of Defense, as appropriate.

Paragraph (4) of new subsection (d).—Would define the term "primary beneficiary"—the term used in paragraph 3 of new subsection (b) of section 5011 (as proposed to be added by clause (4) of this subsection) to describe those individuals whose access to or priority for health-care services is not to be affected adversely by sharing agreements—to mean (A) with respect to the VA, a veteran or other person (dependents of veterans under certain limited circumstances pursuant to section 613 of title 38) eligible under title 38, other than by virtue of a sharing agreement under new subsection (b) of section 5011 of that title (as proposed to be added by clause (4) of this subsection) for health care in VA facilities, and (B) with respect to the Department of Defense, a member or former member of the Army, Navy, Air Force, or Marine Corps or other person (dependents of such members or former members under the conditions prescribed in section 1076 of title 10 and for the care specified in section 1077 of such title) who is eligible for medical and dental care under title 10. The difference between the definition in this paragraph and the one in paragraph (2) ("beneficiary") is that "primary beneficiary"is defined with specific reference to each of the two agencies and the term, as to the VA, expressly excludes those persons eligible for care in VA facilities under sharing agreements entered into under new subsection (b) of section 5011 of title 38 (as proposed to be added by clause (4) of this subsection).

Paragraph (5) of new subsection (d).—Would define the term "health-care resource"—a term used in paragraph (2) of new subsection (b) of section 5011 (as proposed to be added by clause (4) of this subsection) to describe what may be shared pursuant to an interagency agreement—to mean any health-care resource and any health-care support or administrative resource. The term would also expressly include hospital care, medical services, and rehabilitative services as those terms are defined in paragraphs (5), (6), and (8), respectively, of present section 601 of title 38.

Paragraph (1) of new subsection (e).—Would authorize the Administrator, during a period of war declared by the Congress or a period of national emergency declared by the President or the Congress that involves the use of United States Armed Forces in armed conflict—

(A) to give a higher priority to furnishing hospital care, nursing home care, and medical services under chapter 17 of title 38 to active-duty members of the Armed Forces than to any other group of persons except veterans with service-connected disabilities; and

(B) to the extent authorized by the President and subject to the availability of appropriations or reimbursements from the Department of Defense for care provided to active duty members of the Armed Forces, to contract with private facilities for the provision of hospital care and medical services as defined in paragraph (2)(A) of this new subsection, to provide hospital care or medical services on a contract basis for certain veterans.

These authorities could be exercised only pursuant to regulations prescribed by the Administrator.

Paragraph (2)(A) of new subsection (e).—Would define health care and medical services as (and, thus, in conjunction with paragraph (1) of this new subsection, authorize the Administrator to contract with private facilities for)—

(1) hospital care or medical services for the care or treatment of a condition for which the veteran is receiving outpatient treatment from the VA (under either section 612(f), relating to VA outpatient care for a service-connected disability, or for any disability of a veteran who has a service-connected disability rated at 50 percent or greater or who is a former prisoner of war, or for the pre- or post-hospital care of the non-service-connected disability of a veteran eligible for hospital care under section 610 or for care that would obviate the need for hospital care for the treatment of such a disability, or section 612(g), relating to VA outpatient care for a non-service-connected disability of a veteran of the Mexican border period or of World War I, or of certain severely disabled veterans who are in need of aid and attendance or who are housebound) in any case in which it is the medical judgment of the Chief Medical Director, pursuant to regulations prescribed by the Administrator that the delay in furnishing the care at the VA facility concerned would result in a significant deterioration of the condition for which VA care has been provided; and

(2) hospital care for a medical emergency which poses a serious threat to the life or health of a veteran eligible for VA hospital care if the Chief Medical Director pursuant to regulations prescribed by the Administrator, finds that a substantial portion of the resources of the facility involved are being used to provide care to active-duty members of the armed services pursuant to the authority provided in this subsection. Contract care under this clause, as compared to the care authorized under clause (1) of this paragraph, is more limited in authorizing only hospital care in emergency situations for veterans who are not under a continuing VA care obligation. Care under clause (1) includes both hospital care and medical serv-

ices so as to ensure the continuity of care needed to prevent a significant deterioration of the condition of a veteran under VA care during a period of war or national emergency.

By the criterion in clause (2) requiring a determination that "a substantial portion of the resources of the facility involved are being used to provide care to active-duty members of the Armed Forces" before contract care would be authorized, the Committee intends that contract care under this clause be authorized when it is clear that the VA facility where the emergency care is sought is caring for significant numbers of combat casualties. It is not the Committee's intent to limit the availability of this contract authority to situations in which every bed in the VA facility is being utilized for such casualties, but rather that this new contract authority not be available when the facility in question is treating only a very limited number of active-duty personnel and is generally unable to provide care to appreciable numbers of non-service-connected disabled veterans because of competing applications by other veterans.

Paragraph (2)(B) of new subsection (e).—Would provide that the cost of any care provided to active-duty members of the Armed Forces pursuant to the authority established in paragraph (1) of this subsection would be reimbursed to the VA by the Department of Defense at rates agreed upon by the two agencies based on the cost of the care provided. These reimbursements would be credited to appropriations available to the VA facility providing the care.

Paragraph (3) of new subsection (e).—Would require that, within 90 days after the declaration of a war or of a national emergency involving the use of United States Armed Forces in armed conflict, or as soon thereafter as is reasonably practicable, the Administrator report to the Veterans' Affairs Committees of the House of Representatives and the Senate on the Administrator's plans to allocate VA health-care resources, including facilities and personnel, in order to provide priority hospital care and medical services to members of the Armed Forces on active duty. After this report is submitted, the Administrator would be required to keep the two Committees apprised on a periodic basis of the extent to which the authority to contract with private facilities for the care of veterans has been utilized and the circumstances of such utilization.

Subsection (b) of section 4 would amend the item relating to section 5011 in the table of sections at the beginning of chapter 81 to reflect the amendment to section 5011's title as proposed to be made by subsection (a) of this section.

Subsection (c) of section 4 would require the Administrator and the Secretary of Defense, within 180 days after the date of enactment of this bill, to enter into an agreement pursuant to which they shall agree to pursue planning activities and to establish procedures and guidelines to carry out the provisions of new subsection (e) of section 5011 as proposed to be added by clause 4 of subsection (a) of this section.

AGENCY REPORTS

In response to the Committee's request for a report on S. 266 as referred to the Senate Committee on Veterans' Affairs, the Department of Defense, Veterans' Administration, and Office of Management and Budget submitted reports on June 19, and August 12, 1981, respectively. In addition, in response to a request for comments on Amendment 62 to S. 636, the Veterans' Administration reported on September 15, and the Federal Emergency Management Agency reported on September 24, 1981.

* * * * * * *

CHANGES IN EXISTING LAW MADE BY S. 266 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38—UNITED STATES CODE

* * * * * * *

PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

* * * * * * *

CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.

5001. Definitions.
5002. Acquisition of medical facilities.
5003. Authority to construct and alter, and to acquire sites for, medical facilities.
5004. Congressional approval of certain medical facility acquisitions.
5005. Structural requirements.
5006. Construction contracts.
5007. Reports to congressional committees.
5008. Contributions to local authorities.
5009. Garages and parking facilities.
5010. Operation of medical facilities.
5011. [Use of Armed Forces facilities] *Sharing of Veterans' Administration and Department of Defense health-care resources.*
5012. Partial relinquishment of legislative jurisdiction.
5013. Property formerly owned by National Home for Disabled Volunteer Soldiers.
5014. Use of federally owned facilities; use of personnel.
5015. Acceptance of certain property.

* * * * * * *

Subchapter I—Acquisition and Operation of Medical Facilities

* * * * * * *

§5011. [Use of Armed Forces facilities] *Sharing of Veterans' Administration and Department of Defense health-care resources*

(a) The Administrator and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of

use of hospital and domiciliary facilities, and such supplies, equipment, [and material as may be needed to operate such facilities properly, or for the transfer, without reimbursement of appropriations, of facilities, supplies, equipment, or material necessary and proper for authorized care for veterans, except that at no time shall the Administrator enter into any agreement which will result in a permanent reduction of Veterans' Administration hospital and domiciliary beds below the number established or approved on June 22, 1944, plus the estimated number required to meet the load of eligibles under this title,] *material, and other resources as may be needed to operate such facilities properly, except that at no time shall the Administrator enter into any agreement which will result in a permanent reduction of Veterans' Administration beds below any minimum number prescribed by law* or in any way subordinate or transfer the operation of the Veterans' Administration to any other agency of the Government.

(b) After considering the recommendations made under section 3(c)(3) of the Veterans' Administration and Department of Defense Health-Care Resources Sharing Act, the Administrator and the Secretary of Defense shall jointly establish guidelines for the sharing of health-care resources to the maximum extent feasible consistent with the health-care responsibilities of the Veterans' Administration and the Department of Defense under law. Such guidelines shall be established not later than nine months after the date of enactment of this subsection, and (notwithstanding any other provision of law) shall include provisions for the following:

(1) The director or the commanding officer of each health-care facility under the jurisdiction of either of the two agencies shall, to the maximum extent feasible, appropriate, and consistent with such respective responsibilities, enter into sharing agreements with the head of each health-care facility of the other agency in the same geographic area under which those eligible beneficiaries of one agency who are identified in the agreement may be provided health care at the facility of the other agency.

(2) Each such agreement shall explicitly identify the health-care resources to be shared, the health care to be provided, and the beneficiaries to be treated. Resources to be shared may include any health-care resource.

(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis from the facility of the other agency and shall not (as determined by the heads of the facilities concerned) adversely affect the range of services, quality of care, or priority for services provided to the primary beneficiaries of such providing agency.

(4) Each such agreement shall be submitted on the same day to the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter referred to as the "Assistant Secretary") and shall become an interagency agreement (A) on the forty-sixth day following receipt by such officials, unless earlier disapproved by either such official, or (B) if earlier approved by both such officials, on the date of such approval.

(5) Each such agreement shall provide that the agency providing the health-care services will be reimbursed by the other

agency for the cost of care and services provided. Such reimbursement shall be based upon a methodology, agreed upon by the Chief Medical Director and the Assistant Secretary, which provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and needs and the actual costs to the facility being reimbursed. Such reimbursements shall be credited to appropriations available to the facility which provided such care or services.

(c) The Administrator and the Secretary of Defense shall, each year at the time the President's Budget is transmitted to Congress, jointly submit a report to Congress on the implementation of subsection (b) of this section during the fiscal year that ended during the previous calendar year. Each such report shall include information with regard to—

(1) the guidelines and any revisions thereof prescribed pursuant to subsection (b) of this section;

(2) the assessment of opportunities, identified under section 3(c)(2) of the Veterans' Administration and Department of Defense Health-Care Resources Sharing Act, for coordination and sharing of health-care resources between the two agencies;

(3) the recommendations, made under section 3(c)(3) of such Act, for changes in policies and procedures in order to produce maximum feasible interagency coordination and sharing of such resources as authorized by this title;

(4) a review of the interagency sharing agreements entered into by health-care facilities of the two agencies;

(5) the activities of the two agencies under such agreements;

(6) other interagency coordination, planning, and activities involving either agency directed toward producing the maximum feasible efficient use of Federal health-care resources during the preceding fiscal year; and

(7) such legislative recommendations as the Administrator and the Secretary of Defense consider appropriate to facilitate interagency sharing of health-care resources between and by the two agencies.

(d) For the purposes of this section:

(1) The term "direct health care" means health care provided to a beneficiary in a facility operated by the Veterans' Administration or the Department of Defense.

(2) The term "beneficiary" means (A) a veteran or other person who is eligible under this title for health care in Veterans' Administration facilities, or (B) a member or former member of the Army, Navy, Air Force, or Marine Corps or other person who is eligible for medical and dental care under title 10.

(3) The term "providing agency" means the Veterans' Administration or the Department of Defense, as appropriate.

(4) The term "primary beneficiary" means (A) with respect to the Veterans' Administration a veteran or other person who is eligible under this title (other than by virtue of subsection (b) of this section) for health care in Veterans' Administration facilities, and (B) with respect to the Department of Defense a member or former member of the Army, Navy, Air Force, or Marine Corps or other person who is eligible for medical and dental care under title 10.

(5) The term "health-care resource" means any health-care resource and any health-care support or administrative resource, including hospital care, medical services, and rehabilitative services as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 601 of this title.

(e)(1) During a period of war declared by the Congress or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, notwithstanding any other provision of this title, the Administrator may (pursuant to regulations which the Administrator shall prescribe)—

(A) give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, to the extent authorized by this subsection, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities; and

(B) to the extent authorized by the President and subject to the availability of appropriations or reimbursements under paragraph (2)(B) of this subsection, contract with private facilities for the provision by such facilities of hospital care and medical services described in paragraph (2)(A) of this subsection during a period of war or national emergency as described in this paragraph.

(2)(A) Hospital care and medical services referred to in paragraph (1)(B) of this subsection are—

(i) hospital care or medical services authorized under this title for a veteran and necessary for the care or treatment of a condition for which the veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which the delay involved in furnishing such care or services at the Veterans' Administration facility concerned would, in the judgment of the Chief Medical Director pursuant to regulations prescribed by the Administrator, be likely to result in a significant deterioration of that condition; and

(ii) hospital care for a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care under chapter 17 of this title, if the Chief Medical Director pursuant to regulations prescribed by the Administrator, finds that the Veterans' Administration facility concerned is utilizing a substantial portion of its hospital care capability for the furnishing of priority care to members of the Armed Forces under paragraph (1) of this subsection.

(B) The cost of any care or services provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense based on the cost of such care or services provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided such care or services.

(3) Within ninety days after the declaration of a period of war or national emergency described in paragraph (1) of this subsection (or as soon after the end of such ninety-day period as is reasonably practicable), the Administrator shall submit to the committees a

report on the allocation of facilities and personnel in order to provide priority hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. Thereafter, the Administrator shall report periodically to the committees regarding the extent to which, and the circumstances under which, the authority to contract with private facilities provided in paragraph (1)(B) of this subsection is being used.

* * * * * * *

APPENDIX E

I

Union Calendar No. 188

97TH CONGRESS
1ST SESSION

H. R. 3502

[Report No. 97–72, Parts I and II]

To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense.

IN THE HOUSE OF REPRESENTATIVES

MAY 7, 1981

Mr. MOTTL (for himself, Mr. MONTGOMERY, Mr. HAMMERSCHMIDT, Mr. EDWARDS of California, Mrs. HECKLER, Mr. DANIELSON, Mr. WYLIE, Mr. BRINKLEY, Mr. HILLIS, Mr. EDGAR, Mr. SAWYER, Mr. APPLEGATE, Mr. SOLOMON, Mr. LEATH of Texas, Mr. MCEWEN, Mr. BONER of Tennessee, Mr. DUNN, Mr. MICA, Mr. SMITH of New Jersey, Mr. DASCHLE, Mr. SMITH of Alabama, Mr. GRAMM, Mr. MURPHY, Mr. DORGAN of North Dakota, Mr. WON PAT, and Mr. HEFNER) introduced the following bill; which was referred jointly to the Committees on Armed Services and Veterans' Affairs

MAY 19, 1981

Reported from the Committee on Veterans' Affairs

OCTOBER 27, 1981

Additional sponsors: Mr. SAM B. HALL, JR., and Mr. HOWARD

OCTOBER 27, 1981

Reported from the Committee on Armed Services with an amendment, committed to the Committee of the Whole House on the State of the Union, and ordered to be printed

[Omit the part struck through and insert the part printed in italic]

A BILL

To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Administration and Department of Defense Medical Sharing Act".

SEC. 2. (a) Section 5011 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "The Administrator";

(2) by striking out "or for the transfer" and all that follows through "care for veterans,";

(3) by striking out "and domiciliary beds below the number established or approved on June 22, 1944" and inserting in lieu thereof ", domiciliary, and nursing home beds below the number established or approved under section 5010 of this title"; and

(4) by adding at the end the following:

"(b)(1) It is the sense of the Congress that there are opportunities for greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense which, if achieved, would be beneficial to both veterans and to members of the Armed Forces on active duty and which could result in reduced costs to the

Government. Accordingly, the Administrator and the Secretary of Defense shall direct that the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, respectively, form an interagency committee to maintain oversight of opportunities for sharing of medical resources of the Veterans' Administration and the Department of Defense and to make recommendations to the heads of their respective agencies with respect to the sharing of those medical resources.

"(2) In addition to such other duties as may be assigned to them in order to carry out this subsection, the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the 'Assistant Secretary') shall regularly—

"(A) assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;

"(B) keep the other apprised of plans for any additional medical facilities planned by their respective agencies (including the location of new facilities and the acquisition of major new medical equipment) with regard to the impact of such plans on opportunities for interagency sharing;

"(C) review the existing capabilities of the Veterans' Administration and of the Department of Defense with respect to direct health care (including support and administrative services) in order to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either the Veterans' Administration or the Department of Defense; and

"(D) recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of the medical resources of the Veterans' Administration and the Department of Defense.

"(3) In carrying out the duties prescribed by this subsection, the Assistant Secretary shall consult regularly with the Surgeons General of the Army, Navy, and Air Force.

"(4) The Chief Medical Director and the Assistant Secretary may each carry out their respective functions under this subsection through any other official designated for such purpose.

"(c) Not later than one year after the date of the enactment of this subsection, and after considering the recommendations of the Chief Medical Director and the Assistant Secretary submitted under subsection (b) of this section, the Administrator of Veterans' Affairs and the Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. Such guidelines shall include provisions for the following:

"(1) The director, in the case of a health care facility of the Veterans' Administration, or the medical or dental officer in charge, or the contract surgeon in charge, in the case of a health care facility under the jurisdiction of the Department of Defense may enter into cooperative sharing agreements with health care facilities of the other agency. Under any such agreement, an individual entitled to direct health care in a facility of one agency may be provided medical care at the facility of the other agency.

"(2) Each agreement entered into pursuant to paragraph (1) of this subsection between the head of a facility of the Veterans' Administration and the head of a facility of the Department of Defense shall explicitly define the health care to be provided pursuant to such agreement. Services to be shared may include any medical resource, but the resources to be shared shall be negotiated and agreed upon by the heads of the facilities entering into the agreement.

"(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the range of services, quality of care, or priority access for services of the primary beneficiaries of the providing agency.

"(d)(1) Whenever a beneficiary receives medical services from a providing agency other than the providing agency for which such beneficiary is a primary beneficiary, the providing agency shall be reimbursed for the cost of the services provided based on any costing methodology agreed upon by the Administrator and the Secretary of Defense that is based on the cost of the services provided.

"(2) Any reimbursement under paragraph (1) of this subsection shall be credited to the appropriation and to the facility that provided the services.

"(e) The Administrator and the Secretary of Defense shall submit an annual joint report to Congress, to be submitted at the time the President's Budget for the next fiscal year is transmitted, with regard to—

"(1) the guidelines prescribed pursuant to subsection (c) of this section;

"(2) the opportunities for interagency sharing determined under subsection (b)(2) of this section;

"(3) the interagency sharing agreements entered into by health-care facilities of the Veterans' Administration and the Department of Defense;

"(4) the activities of the Veterans' Administration and the Department of Defense under such interagency sharing agreements;

"(5) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

"(6) the progress of Federal interagency medical resource sharing during the preceding fiscal year;

"(7) the interagency coordination of Federal health resources planning;

"(8) other major Federal activities to increase interagency sharing of Federal medical resources; and

"(9) such legislative recommendations as they consider appropriate to facilitate interagency sharing of health care resources.

"(f) For the purposes of this section:

"(1) The term 'direct health care' means health care provided to a beneficiary in a facility operated by the United States Government.

"(2) The term 'beneficiary' means a veteran who is entitled under this title to health care in Veterans' Administration facilities or a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

"(3) The term 'providing agency' means the Veterans' Administration or the Department of Defense.

"(4) The term 'primary beneficiary', with respect to the Veterans' Administration, means a veteran who is entitled under this title to health care in Veterans' Administration facilities, and, with respect to the Department of Defense, means a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

"(5) The term 'medical resource' means medical care resources and medical care support resources.

"(g)(1) Notwithstanding any other provision of this title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, as authorized by this section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

"(2)(A) The Administrator may contract with private facilities for the provision by such facilities of hospital care and medical service described in subparagraph (B) of this paragraph during a period described in paragraph (1) of this subsection in which the President has authorized the Veterans' Administration to furnish priority medical care and services to members of the Armed Forces on active duty.

"(B) Hospital care and medical services referred to in subparagraph (A) of this paragraph are—

"(i) hospital care needed to treat a condition for which a veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition; and

"(ii) hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care or services under chapter 17 of this title, if Veterans' Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under paragraph (1) of this subsection.

"(C) The Administrator shall prescribe regulations to govern contracting under this paragraph.

"(D) The authority of the Administrator to enter into contracts under this paragraph is subject to the availability of appropriations for that purpose.

"(3) The cost of any care or service provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense and are based on the cost of the care or service provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided the care or service.

~~"(4) The Administrator and the Secretary of Defense may, without further review of such requests within the executive branch, submit requests to Congress (A) for relief from applicable personnel ceilings or other administrative restrictions, when such relief is needed in order to carry out this subsection, or (B) for appropriations to carry out this subsection.~~

~~"(5) Within 30 days after an authorization by the President under paragraph (1) of this subsection for the Veterans' Administration to provide priority hospital care and service to members of the Armed Forces on active duty (or as soo after the end of such thirty-day period as is reasonably practi cable), the Administrator shall submit to the Committees o~~

~~Veterans' Affairs of the Senate and House of Representatives a report of the Administrator's plan for the allocation of facilities and personnel in order to provide such care and services.~~

~~"(6) During a period of war or national emergency described in paragraph (1) of this subsection, the Secretary of the military department concerned, upon the recommendation of the Administrator, may relieve any officer or employee of the Veterans' Administration whose duties concern the furnishing of care and services under chapter 17 of this title from any obligation to perform active military service which such officer or employee would otherwise be required to perform.".~~

"(4) The Administrator shall maintain current plans for the provision of hospital care and medical services under this subsection to members of the Armed Forces on active duty. Such plans shall ensure that Veterans' Administration medical facilities are prepared to begin accepting members of the Armed Forces for such care and services as soon as practicable, and not more than forty-eight hours, after an authorization by the President under paragraph (1) of this subsection. Such plans shall be reviewed jointly by the Administrator and the Secretary of Defense not less often than annually, and any modification in such plans shall be reported to the Committees on Veterans' Affairs and Armed Services of

the Senate and House of Representatives within thirty days after such modification is agreed to.".

(b)(1) The heading of such section is amended to read as follows:

"§ 5011. Sharing of Veterans' Administration and Armed Forces facilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5011. Sharing of Veterans' Administration and Armed Forces facilities.".

(c) The Administrator of Veterans' Affairs shall enter into an agreement with the Secretary of Defense not later than one hundred and eighty days after the date of the enactment of this Act under which the Administrator and the Secretary shall agree to pursue planning activities and to establish procedures and guidelines under which subsection (g) of section 5011 of title 38, United States Code, as added by subsection (a), may be carried out.

APPENDIX F

97TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 97-72
1st Session } { PART 1

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE MEDICAL SHARING ACT

MAY 19, 1981.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MONTGOMERY, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany H.R. 3502 which on May 7, 1981 was referred jointly to the Committees on Armed Services and Veterans' Affairs]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 3502) to amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense, having considered the same, reports favorably thereon by unanimous voice vote without amendment and recommends that the bill do pass.

BACKGROUND

The Veterans' Administration operates the largest health care delivery system in the United States that is under single management. At the present time, it includes 172 hospitals and 228 outpatient clinics. It currently operates approximately 82,500 hospital beds, 9,000 nursing care beds, and 9,217 domiciliary beds. It provides inpatient care to 1.24 million patients per year and outpatient visits of 17.8 million.

To care for these patients, the VA employs 185.000 personnel, including 6,300 full-time, 4,100 part-time and 7,500 intern and resident physicians. In addition, the VA employs 880 full-time, 29 part-time, and 283 intern and resident dentists and over 28,000 registered nurses.

H.R. 2158, the Military/Veterans' Administration Medical Sharing Act of 1981, was introduced on February 25, 1981 by the Honorable Ronald M. Mottl, the Chairman of the Subcommittee on Hospitals and Health Care. The bill is designed to provide for greater coordination and sharing of the medical resources of the Veterans' Administration and the Department of Defense.

On February 19, 1981, the Honorable Marvin Leath of Texas introduced H.R. 1969, the Military Casualty Medical Treatment Planning Act of 1981. The bill is designed to designate the VA health care delivery system as the principal back-up health care system to the Department of Defense in case of war or national emergency.

The Subcommittee on Hospitals and Health Care conducted hearings on both H.R. 1969 and H.R. 2158 on March 25, 1981. Testimony was received from the Paralyzed Veterans of America, Veterans of Foreign Wars, The American Legion, the Disabled American Veterans, the Noncommissioned Officers Association of the United States, the Department of Defense, and the Veterans' Administration.

On April 30, 1981, the Subcommittee recommended a clean bill, H.R. 3502, to the full Committee, encompassing the provisions of H.R. 1969 and H.R. 2158. On May 12, 1981, the full Committee, by unanimous voice vote, ordered the bill reported to the House for consideration.

SUMMARY OF THE BILL

The basic purpose of Sections 2(a) through 2(f) of the reported bill is to encourage greater sharing of medical resources between the Veterans' Administration (VA) and Department of Defense (DOD). The bill is intended to overcome the many obstacles to such sharing that have been identified by the Veterans' Administration, Department of Defense, the General Accounting Office, and others. This bill establishes a clear legislative mandate for sharing between the Veterans' Administration and the Department of Defense and encourages the pursuit of such sharing arrangements that would be beneficial to the primary beneficiaries of the Veterans' Administration and the Department of Defense and/or that would result in reduced costs to the government.

The purpose of Section 2(g) of the bill is to establish formally the role of the Veterans' Administration health care system as the primary back-up to the Department of Defense health care system for treatment of members of the Armed Forces of the U.S. engaged in armed conflict during a period of war, or national emergency declared by the President or the Congress. This legislation establishes a fourth mission for the VA health care system and would allow VA and DOD to develop systematic plans for establishing a contingency hospital system.

MAJOR PROVISIONS OF THE BILL

Sections 2(a) through 2(f) would direct the establishment of an interagency committee, composed of the Chief Medical Director of the VA and the Assistant Secretary of Defense for Health Affairs, which would maintain oversight of opportunities for sharing medical resources and make recommendations to the Administrator and the Secretary of Defense with respect to the sharing of such medical resources. The duties assigned to this interagency committee would include the following:

(a) Assess the opportunities for sharing of existing medical resources between the VA and DOD;

(b) Keep each other apprised of plans for any additional medical facilities planned by their respective agencies, including the acquisition of major new medical equipment, with regard to the impact of such plans on opportunities for interagency sharing;

(c) Review existing capabilities of the VA and DOD to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either agency; and

(d) Recommend to the Administrator and the Secretary of Defense policies and procedures to maximize the implementation of this bill.

In carrying out these duties, and, after considering the recommendations of the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs, the Administrator and the Secretary of Defense would be required to jointly establish guidelines for the sharing of medical resources within one year after the date of enactment of this bill. Such guidelines would be required to include the following:

(a) Provide that the individual facility director or the officer in charge may enter into cooperative sharing agreements;

(b) Provide that individuals entitled to direct health care in a facility of one agency may, pursuant to an explicitly defined agreement, be provided medical care at a facility of the other agency;

(c) Provide that each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency (individuals entitled to direct health care in VA facilities or, for DOD, members or former members of the Armed Forces) shall be on a referral basis and not adversely affect the range of services, quality of care, or priority access for services to primary beneficiaries of the providing agency; and

(d) Provide that reimbursement for such services would be based on a costing methodology agreed upon by the Administrator and the Secretary of Defense and be based on the actual cost of the services provided; and such reimbursements would be credited to the appropriation of the facility that provided the services.

The reported bill calls for an annual joint report to Congress to be submitted at the time of the President's budget for the next fiscal year with regard to sharing accomplishments during the preceding fiscal year, problems encountered, future plans, and recommendations for additional legislative authority.

Section 2(g) recognizes the need for the VA and DOD to participate in joint contingency planning. Recognizing the need to provide maximum flexibility to the VA health care system to meet this new mandate, this legislation would establish a special priority for treating members of the Armed Forces during a period of war or national emergency. This priority would be second only to the priority of service-connected veterans for care and treatment.

This subsection would also provide special contract authority during such a period of war or national emergency to permit the Administrator, pursuant to regulations to be prescribed, to furnish (1) hospital care for veterans currently receiving outpatient medical services under subsections (f) and (g) of Section 612 of title 38, United States Code, if delay in furnishing such hospital care would be likely to result in deterioration of the veteran's condition, and (2) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing such care because of furnishing care to members of the Armed Forces under this new authority.

It would provide for reimbursement from DOD to the VA at such rates as are agreed upon by the Administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursement to the VA would be credited to the VA facility providing the care or service.

The bill provides that the VA and DOD, without further review of such requests within the executive branch, would have authority to submit requests directly to Congress for relief from personnel ceilings or for appropriations to carry out the purposes of the bill. The measure also makes provision for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable) to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

This subsection would also authorize the Secretary of the military department concerned during the period of war or national emergency to relieve VA employees whose duties concern the furnishing of care and services under chapter 17 of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform. The measure would also direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

Discussion of the Bill

Sharing

This legislation is not intended to alter the complete autonomy and separate statutory responsibilities of the Department of Defense and the Veterans' Administration. The scope of interagency sharing that would be permitted under this legislation would not extend to the point of co-mingling or the altering of agency missions or management. It is intended solely to establish a legislative mandate for interagency sharing and to foster the mutual exchange of information between the Department of Defense and the Veterans' Administration for the purpose of identifying opportunities for greater sharing of medical resources when it is beneficial to the VA and the Department of Defense. The legislation would remove legal and other obstacles that have constrained interagency sharing and would create the mechanisms necessary to overcome the problem of handling the reimbursements for such sharing agreements and setting the rates for such reimbursements.

The Committee is aware of the activities of the Federal Health Resources Sharing Committee which have been devoted to the issues surrounding interagency planning for, and sharing of, health care resources. While this body was voluntary and has done a commendable job, it has not had the formal official sanction necessary to fully accomplish the task of enhancing sharing between the Veterans' Administration and the Department of Defense. The interagency committee established by this legislation is intended to replace the Federal Health Resources Sharing Committee with respect to the sharing activities of the VA and the Department of Defense. The Committee feels that the membership and the activities of this committee established in law will provide the mechanism required for the VA and DOD to actively pursue joint sharing arrangements.

This legislation defines the term "beneficiary" as a veteran who is entitled under title 38, United States Code, to health care in the VA system or, for the Department of Defense, as a member or former member of the Army, Navy, Air Force or Marine Corps, who is entitled to medical and dental care under section 1074 of title 10, United States Code. The Committee feels that this distinction is appropriate and that military dependents should not be entitled to receive health care services at a VA facility except on an emergency, humanitarian basis.

Although this legislation stipulates that the resources to be shared should be negotiated and agreed upon by the heads of the facilities entering into agreements, this provision does not preclude each agency head from requiring such agreements to be approved by its central office, nor does it prevent each agency from establishing their own internal procedures for the reporting and monitoring of such activities.

The Committee notes that the sharing authority provided in section 5053 of title 38, United States Code, deals with the sharing of specialized medical resources only. The Committee is also aware that this authority has been used to share only excess capacity that has been created exclusively for the health care of veterans. This legislation is not intended to alter these authorities nor preclude their continued use. The reported bill would expand the current limitation in existing law to allow for a sharing of planning information between the VA and DOD to identify possible future plans for added capacity that lend themselves to appropritae sharing arrangements under the provisions of this bill. In this regard, this sharing authority is not limited to existing excess capacity, including staff, equipment, space, or other health care resources. Also, this legislation is not restricted solely to specialized medical resources but rather includes all medical care resources and all medical care support services at VA field facilities, including support and administrative services.

Contingency planning

Section 2(g) of this legislation, to formally establish a fourth VA mission to assist DOD in the treatment of casualties resulting from the involvement of the Armed Forces of the United States in armed conflict or national emergency, is the result of discussions that have been taking place between DOD and representatives of the Veterans' Administration regarding support that the VA could provide during such a period. DOD contracted with the consulting firm, Maximus, Inc., to study this issue and in December 1979 a report was published titled "The Potential Use of the Facilities and Medical Manpower of the Veterans' Administration and the Public Health Service in Time of Limited War." This study found that DOD and VA should continue their efforts to develop and maintain a working contingency system which enhances mutual preparedness for a limited war. It made specific recommendations to intensify joint VA/DOD planning efforts to develop specific contingency plans, and to develop a legislative proposal to permit higher priority in VA hospitals for care of active duty patients in time of war. Based on this study and due to reassessments of their own capabilities and reassessments of the immediate impact of possible future armed conflicts, the Department of Defense has been actively planning and developing a contingency medical capability.

The General Accounting Office reported to the Congress on the activities of DOD in this regard in a report (HRD-80-76) entitled "The Congress Should Mandate Formation Of A Military-VA-Civilian Contingency Hospital System," dated June 26, 1980. This report discusses the activities of DOD and the VA directed toward the development of a medical backup capability, and contains recommendations to the Congress for legislation needed to facilitate this activity. With regard to the VA, the report recommends that the Congress enact legislation which provides that both DOD and the VA fully participate in Federal medical planning for the care of returning wartime casualties. According to the GAO, such legislation should:

> "Give VA the mission of providing direct medical support to DOD for treating all categories of battlefield casualties."
>
> "Place battlefield casualties above veterans with nonservice-connected, nonemergency conditions in VA's priority for care."
>
> "Remove numerous obstacles to interagency sharing, as we previously recommended, so that VA and DOD may establish a strong peacetime medical resources sharing program to serve as an effective foundation for a military-VA-civilian contingency hospital system."

In support of these recommendations, the General Accounting Office found that further delay in adding this mission to the VA's current responsibilities could result in:

> "Unnecessary confusion during mobilization regarding where returning casualties should be sent for medical care."
>
> "Underuse of VA's medical capabilities during war or conflict."
>
> "Inability of DOD to know what the total federal wartime medical capability is to identify the shortage which needs to be made by the civilian sector."
>
> "Unnecessary effort and expense by DOD to identify and contract for civilian medical resources."

The need to be prepared for a possible armed conflict by planning to appropriately use federal medical resources before calling on civilian resources is apparent. The Committee feels that the VA, as a federal medical care system whose mission is closely associated with the defense of the nation, should have, as part of its mission, a direct support role for the treatment of battlefield casualties. The Committee believes that a contingency hospital system so configured would provide the most efficient and effective use of federal medical capability in such periods of war or national emergency. The VA hospital system encompasses a vast array of facilities in every state (except Alaska and Hawaii) each of which has direct involvement with the local medical community and local community hospitals. Also, the majority of the VA hospitals are affiliated with most of the nation's medical schools and have close working relationships with these institutions, their university medical centers and other affiliated hospitals. The VA affiliation with medical schools and associated institutions has the potential to greatly expand this contingency capability. Such a relationship would also bring under the umbrella of the contingency back-up system the extensive specialized medical resources and capabilities of the affiliated medical schools and university medical centers.

In order for the VA to participate in the planning for the care of returning battlefield casualties, legislative modifications to the VA mission and responsibilities are required. Currently, hospital care to members of the Armed Forces expected to return to active duty would be on a low priority basis and would be subject to the resources available to the VA system at the time of such an emergency. As a result, the VA currently cannot make long-range assurances or commitments to DOD for treatment of such casualties. This bill is designed to give the VA this mission and provide the flexibility needed to allow DOD and the VA to jointly plan for such contingencies.

The Committee recognizes and endorses the need to establish a special priority for the treatment of members of the Armed Forces under the authority established in this bill. The Committee also recognizes the equally important need to provide special contract authority (1) for the continuation of medical care to veterans that are under the care of the VA system at the onset of a national emergency, and (2) care for eligible veterans who present themselves to the VA system with a condition that is medically emergent and poses a serious threat to life or health of the veteran. The Committee intends that this authority only be used at those facilities which are providing care to such members of the Armed Forces. The Committee intends that the denial of care to otherwise eligible veterans under this authority would occur only after the capacities of such participating facilities become fully utilized by the furnishing of care and services to members of the Armed Forces under the circumstances set forth in this bill. For example, the implied authority to deny care to nonservice-connected veterans who are otherwise eligible and who are not medically emergent and are not currently under the care of the VA would extend only to those facilities which are actively participating in the contingency hospital system supporting the Department of Defense and would only be invoked as the capacities of those facilities become utilized for the furnishing of care and services to such members of the Armed Forces. In addition to providing continuing care for eligible veterans, this special contract authority is also necessary to give the VA flexibility to rapidly expand the capacity of the system during such period of war or national emergency.

This legislation also contains a provision that would authorize the Secretary of the military department concerned, upon the recommendation of the Administrator, to relieve any officer or employee of the VA whose duties concern the furnishing of care and services to eligible veterans from any obligation to perform active military service which such officer or employee would otherwise be required to perform. The Committee anticipates that this authority would only be used for direct health care personnel and would not generally apply to other military reserve personnel employed by the VA. The Committee notes that the Department of Defense and the Veterans' Administration recommend removing this authority from the bill. The Department of Defense, in its prepared testimony, pointed out that procedures (contained in DOD Directive 1200.7) already exist to determine an individual's most appropriate utilization in a mobilization. This legislation is not intended to alter these administrative procedures. This new authority is discretionary and would be implemented only on mutual VA/DOD agreement. This authority does provide additional flexibility to meet unknown future circumstances and events that may develop as a result of such a contingency. The Committee feels that this added flexibility is necessary for the VA to undertake joint contingency planning with the Department of Defense.

SECTION-BY-SECTION ANALYSIS

Section 1. This section cites the title of the bill as "Veterans' Administration and Department of Defense Medical Sharing Act."

Section 2(a) would amend section 5011 of title 38, United States Code, (1) to specifically eliminate the authority of the Administrator and the Secretaries of the Army, Air Force, and Navy to mutually transfer without reimbursement facilities, supplies, equipment, or material needed and proper for the care of veterans; (2) to require that the Administrator shall not enter into any agreement which would result in a permanent reduction in the number of VA hospital, domiciliary and nursing home beds below the number established or approved under section 5010 of this title instead of the current requirement that the number of hospital and domiciliary beds not be permanently reduced below the number established or approved June 22, 1944; and (3) to add at the end new subsections (b), (c), (d), (e), and (f) (which were originally introduced in H.R. 2158) and (g) (which was originally introduced in H.R. 1969) as follows:

> Subsection (b)(1) would declare that it is the sense of Congress that there are opportunities for greater sharing and coordination of the medical resources of the VA and DOD which would be beneficial to veterans and members of the Armed Forces and which could result in reduced costs to the Government. Therefore, the Administrator and the Secretary of Defense shall direct the Chief Medical Director of the VA and the Assistant Secretary of Defense for Health Affairs to form an interagency committee to maintain oversight of opportunities for sharing of medical resources of both agencies and to make recommendations to the agency heads for the sharing of medical resources;
>
> Subsection (b)(2) would direct the Chief Medical Director and Assistant Secretary of Defense for Health Affairs to regularly:
>
> (A) assess the opportunities for mutual sharing of medical resources;

(B) keep each other apprised of plans of their respective agency for any additional medical facilities and their impact on interagency sharing;

(C) review the existing capabilities of each agency to provide direct health care in order to identify opportunities for sharing that will not adversely affect the quality or priority of care provided by either agency; and

(D) recommend policies and procedures to the heads of both agencies to maximize the sharing of medical resources and provide coordinated planning for future development of their direct health care delivery systems.

Subsection (b)(3) would direct the Assistant Secretary to consult regularly with the Surgeons General of the Army, Navy, and Air Force in carrying out the duties of this subsection.

Subsection (b)(4) would provide that the Chief Medical Director and the Assistant Secretary for Health Affairs may each carry out their respective functions under this subsection through any other official designated for this purpose.

Subsection (c) would provide that the Administrator and Assistant Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of both agencies not later than one year after the enactment of this subsection and after considering the recommendations submitted by the Chief Medical Director and Assistant Secretary. These guidelines shall include provisions for the following:

(1) When possible, the director of a VA health care facility or the officer in charge of a DOD health care facility may enter into cooperative sharing agreements for direct health care at a facility to an individual entitled to care at the facility of the other agency;

(2) That each agreement explicitly define the health care that is to be provided and that shared services shall be negotiated and agreed to by the heads of the facilities and may include any medical resources; and

(3) That each agreement shall ensure that the availability of direct health care and shall be on a referral basis to individuals not primary beneficiaries of the providing agency and shall not adversely affect the range of services of the primary beneficiaries.

Subsection (d) would provide that medical services provided by an agency to the primary beneficiary of the other agency shall be reimbursed on a cost methodology based on the cost of the services rendered and agreed to by both the Administrator and Secretary. Any reimbursement shall be credited to the appropriation and facility that provided the services.

Subsection (e) would provide that the Administrator and Secretary shall submit an annual joint report to the Congress at the time of the transmittal of the President's budget for the next fiscal year with regard to the guidelines and opportunities for the sharing of medical resources, interagency sharing agreements entered into by health facilities of both agencies, the activities of both agencies under these agreements, other interagency activities directed toward maximizing efficient use of Federal health resources as well as the progress of Federal interagency health sharing during the preceding fiscal year, interagency coordination of Federal health resources planning, other major Federal activities to increase interagency sharing of Federal medical resources, and appropriate legislative recommendations to facilitate interagency sharing of health care resources.

Subsection (f) would define the terms "direct health care", "beneficiary", "providing agency", "primary beneficiary", and "medical resource" for the purposes of this section.

Subsection (g)(1) would establish a special priority for VA hospital care, nursing home care, and medical services-for members of the Armed Forces on active duty during a period of war or a period of national emergency declared either by the President or the Congress. This priority would be second only to the priority of service-connected veterans for care and treatment.

Subsection (g)(2)(A) and (B) would provide special contract authority during such a period of war or national emergency to permit the Administrator to furnish (i) hospital care or outpatient services for veterans currently receiving services under section 610 or subsections (f) and (g) of section 612 of title 38, United States Code, if delay in furnishing such care or services would be likely to result in deterioration of the veterans condition, and (ii) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of a veteran, if VA facilities are not capable of furnishing the care or services required because of furnishing care to members of the Armed Forces under paragraph (1) of this subsection.

Subsection (g)(2)(C) directs the Administrator to prescribe regulations governing contracting under this paragraph.

Subsection (g)(2)(D) provides the Administrator's authority to enter into contracts under this paragraph is subject to the availability of appropriations for this purpose.

Subsection (g)(3) would provide for DOD reimbursement to the VA at such rates as are agreed upon by the Administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursements to the VA would be credited to the VA facility providing the care or service.

Subsection (g)(4) would provide that the VA and DOD would have authority to submit requests directly to Congress for relief from personnel ceilings or for appropriations to carry out the purposes of the bill without further review of these requests within the executive branch.

Subsection (g)(5) would provide for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable) to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

Subsection (g)(6) would provide that the Secretary of the military department concerned, during the period of war or national emergency, may relieve VA employees whose duties concern the furnishing of care and services under chapter 17 of title 38, United States Code, from any obligation to perform active military service which such employee would otherwise be required to perform.

Section 2(b) is a technical amendment to reflect the change in the heading of section 5011 and in the table of sections at the beginning of chapter 81 of title 38, United States Code.

Section 2(c) directs the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

OVERSIGHT FINDINGS

An oversight hearing was held on March 25, 1981 on problems relating to sharing of scarce category medical facilities, particularly between the Department of Defense and the Veterans' Administration, and on the designation of the VA health care delivery system as the principal backup system to the Department of Defense in case of war or national emergency.

No oversight findings have been submitted to the Committee by the Committee on Government Operations.

INFLATIONARY IMPACT

There would be no inflationary impact with the enactment of the reported bill.

COST

It should be noted that the enactment of the contingency plan contained in the reported bill would result in costs only during a period of war or national emergency.

The enactment of sections 2(a) through 2(f) of the bill could ultimately result in substantial savings in medical care costs both to the Veterans' Administration and the Department of Defense. The magnitude of such savings, according to the Congressional Budget Office, would be dependent upon the policies and procedures for sharing equipment and facilities established between the two agencies.

12

BUDGET STATEMENT

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., May 14, 1981.

Hon. G. V. MONTGOMERY,
Chairman, Committee on Veterans' Affairs,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 3502, the Veterans Administration and Department of Defense Medical Sharing Act, as ordered reported by the House Committee on Veterans' Affairs, May 12, 1981.

This bill would direct the Administrator of Veterans Affairs and the Secretary of Defense to establish an interagency committee to study the possible opportunities for the sharing of the medical resources of their agencies and to recommend policies and procedures to maximize such sharing. While this bill could eventually result in substantial savings to the federal government through the coordination and sharing of these medical resources, CBO is unable to estimate the magnitude of such savings without knowledge of the new policies and procedures that would ultimately be established.

Sincerely,

RAYMOND C. SCHEPPACH
(For Alice M. Rivlin, Director).

AGENCY REPORT

The Veterans' Administration submitted the following transmittal on H.R. 2158, the Military/Veterans' Administration Medical Sharing Act of 1981, and H.R. 1969, the Military Casualty Medical Treatment Planning Act of 1981:

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS' AFFAIRS,
Washington, D.C., April 9, 1981.

Hon. G. V. (SONNY) MONTGOMERY,
Chairman, Committee on Veterans' Affairs,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: We are pleased to respond to your request for the views of the VA on H.R. 2158, a bill "To amend title 38, United States Code, to provide for greater coordination and sharing of the medical resources of the Veterans' Administration and the Department of Defense."

H.R. 2158 is intended to facilitate interagency sharing of medical care and medical care support resources between the Veterans' Administration (VA) and the Department of Defense (DOD). The bill would mandate that the Secretary of Defense and the Administrator of Veterans' Affairs direct the Assistant Secretary of Defense for Health Affairs and the Chief Medical Director respectively to form an interagency committee to jointly assess opportunities for sharing Federal health resources, to include the potential for sharing in plans for establishing additional VA or DOD medical facilities and for the acquisition of major new medical equipment, and to identify sharing opportunities that will not adversely affect the quality or priority of care provided. H.R. 2158 would further require the two officials to recommend to their respective agency heads policies and procedures to both maximize VA and DOD sharing of medical resources and to provide for coordinated planning for the future development of each agency's direct health care delivery system. In connection with these various duties, the bill would also require that the Assistant Secretary of Defense for Health Affairs consult regularly with the Surgeons General of the Army, Navy and Air Force.

The bill would mandate that the Administrator, VA, and the Secretary of Defense within a year of its enactment jointly establish guidelines for the sharing of medical resources between VA and DOD medical facilities. Such guidelines would include a requirement that the respective VA and DOD health care facility directors would enter into cooperative sharing agreements whenever possible. These agreements would be negotiated between the heads of the facilities concerned and would explicitly define the health care to be provided under the agreement. Under the bill's definitions, both veterans entitled to care in VA facilities and members and former members of the Army, Navy, Air Force or Marine Corps entitled to medical and dental care under title 10, United States Code, would be considered "primary beneficiaries," and as such could be provided medical care at the facility of the other agency, i.e., the agency as to which they are not primary beneficiaries. The agreements would have to assure that the availability of direct health care for such beneficiaries is on a referral basis only, and that any such care rendered non-primary beneficiaries would not adversely affect the range of services, quality of care, or priority access for service of the providing agency's primary beneficiaries. Reimbursement of the providing facility's costs, using any costing methodology based on the cost of service provided, would be as agreed on by the Secretary of Defense and VA Administrator, or their designees, and would be credited to the specific facility which provided the health care services.

H.R. 2158 also contains a requirement for a VA–DOD annual joint report, to be submitted to the Congress as a whole with regard to various aspects of the bill's implementation at the time the President's Budget for the next fiscal year is transmitted.

Although the bill does not specifically so provide, it appears clear that the proposed joint responsibilities of the Secretary of Defense and Administrator of Veterans' Affairs as to uniform direct health care are neither intended to alter VA's or DOD's statutory responsibilities with regard to providing medical services, nor to preclude the sharing of medical resources under any other law, except to the extent that it would amend 38 U.S.C. § 5011 to eliminate the authority of both the VA and the military Department heads to transfer to the other "facilities, supplies, equipment or material" needed in the care of veterans without reimbursement of appropriations.

Congress had the foresight to recognize the utility of the sharing concept for the VA medical care system in the early 1960's. Public Law 89–785, enacted in November 1966, gave the Veterans' Administration specific statutory authority to enter into agreements to receive from and share with medical schools, hospitals, and research centers throughout the country the most advanced medical resources. Congress also had given the Secretaries of the military Departments and the VA Administrator authority, with some exceptions, to enter agreements for the mutual use or exchange of use of hospital and domiciliary facilities, equipment, and supplies, and for the transfer among them of these items without reimbursement (38 U.S.C. § 5011).

Since the enactment of Public Law 89–785, Veterans' Administration sharing activity has grown dramatically. Thus, the number of sharing contracts has increased 15 times between 1967 and now, and in 1979, there were 99 VA medical centers having 240 sharing contracts for a total value of services exchanged amounting to $20,198,677. We are convinced that the sharing agreements have resulted in better cooperation between VA hospitals and their community counterparts, and in better utilization of medical specialists, technologies and facilities.

Together with our sharing efforts with community facilities, VA has enthusiastically sought increased cooperation among Federal medical systems. The VA has for many years been in the forefront among Federal agencies in initiating "cross-servicing" agreements under the Economy Act. These Veterans' Administration agreements involve not only DOD, but other Federal agencies as well, such as the Departments of Health and Human Services, Justice, Energy, and the Office of Personnel Management, NASA, and the Federal Aviation Administration. We believe our extensive activities in this area evidence our commitment to the sharing of Federal medical resources, thereby facilitating medical care cost containment.

As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases to insufficient agency guidance in identfying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle. We believe that adoption of a policy authorizing that reimbursements collected be distributed to the facility that generated the reimbursement would be helpful; H.R. 2158 includes such a provision.

Our own specific sharing authority in section 5053 of title 38, United States Code, is limited in scope to specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at VA Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

In addition, the VA has played an important role in developing greater coordination in health services delivery by Federal agencies through its role on the Federal Health Resources Sharing Committee, whose members represent the Air Force, Army, Navy, DOD, Public Health Service and the VA.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. Within this context, the VA strongly supports the goal of achieving increased interagency cooperation through the sharing of Federal medical resources and of providing incentives to increase such sharing. We agree with the view underlying this bill, that the VA has a potentially important role to play in providing needed medical care or resources for military members. Neither our facilities nor our mission were designed to furnish health care services to military dependents. We believe H.R. 2158 draws an appropriate line in excluding the military dependent from the beneficiary class that might be provided care in VA facilities under this proposal.

The affinity and close association that would readily facilitate increased sharing of medical resources between the VA and the military medical services is relatively unique. We would welcome the opportunity to build on and expand such sharing through incentives. We note, however, that H.R. 2158 is framed in mandatory terms. We would recommend that the measure be given a more permissive cast. H.R. 2158 generally reflects a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DOD have to their respective primary beneficiaries, i.e., veterans and members of the armed services.

Further, we believe the separate identity and special responsibilities of the VA, as well as the military providers, must be maintained. We would not envision, therefore, that this legislation would result in any commingling of responsibilities for management and operation of individual VA or DOD health care facilities.

We would also draw one additional matter to the Committee's attention. H.R. 2158 is silent as to the point at which arrangements between the VA and DOD facility directors would become operative agreements. It would be our understanding that the joint guidelines to be established by the Administrator of Veterans' Affairs and the Secretary of Defense under section 2(c) of the draft bill could include provisions that no such arrangements would become operative until agreed upon by agency headquarters. We consider such review to be essential in view of the magnitude of expenditures involved and the possible impact of such agreements beyond the local facility itself.

In sum, we favor the principle of interagency sharing of medical resources by VA and DOD as embodied in H.R. 2158. If encouraged and facilitated rather than mandated we believe such sharing would tend to enhance the respective abilities of each to accomplish their missions in a cost-effective manner. With a suitable change to permit VA and DOD to take a permissive approach to interagency sharing, we would be pleased to support this bill.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

RUFUS H. WILSON,
Acting Administrator.

17

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, D.C., May 7, 1981.

Hon. G. V. (SONNY) MONTGOMERY,
Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to the request for this Agency's views concerning H.R. 1969, a bill "To amend title 38, United States Code, to authorize the Veterans' Administration to provide medical care on a priority basis to members of the Armed Forces who are injured during a period of war or national emergency, and for other purposes."

H.R. 1969 would establish a special priority for VA hospital care, nursing home care, and medical services for members of the Armed Forces on active duty during a period of war or a period of national emergency declared either by the President or the Congress. This priority would be second only to the priority of service-connected veterans for care and treatment.

The bill would also provide special contract authority during such a period of war or national emergency to permit the Administrator, pursuant to regulations to be prescribed, to furnish (1) hospital care for veterans currently receiving outpatient medical services under subsections (f) and (g) of section 612 of title 38, United States Code, if delay in furnishing such hospital care would be likely to result in deterioration of the veteran's condition, and (2) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing the care or services required because of furnishing care to members of the Armed Forces under this new authority.

H.R. 1969 would provide for DOD reimbursement to the VA at such rates as are agreed upon by the Administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursements to the VA would be credited to the VA facility providing the care or service. The measure also makes provision for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable), to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

This bill would also authorize the Secretary of the military department concerned during the period of war or national emergency to relieve VA employees whose duties concern the furnishing of care and services under chapter 17, United States Code, of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform. The measure would also direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

Finally, section 3 of the bill would amend section 613, title 38, United States Code, to remove restrictive language and thereby facilitate the treatment of CHAMPVA beneficiaries within VA facilities.

We strongly support the desirability of medical contingency planning between the Department of Defense and this Agency. Requirements in the law that VA facilities be maintained to ensure their availability for the treatment of veterans, and that preference in providing medical services be given to various classes of veterans have, however, prevented us from committing the Agency to specific plans for participation in a civilian-military contingency hospital system.

We would point out that the VA has been involved in inter-agency planning and preparation for emergency situations pursuant to the provisions of Executive Order (E.O.) 11490, as amended. This Order, entitled "Assigning Emergency Preparedness Functions to Federal Departments and Agencies," is based on legislative mandates concerned with national security and defense. The VA is expressly charged in Part 29 of the E.O. to "develop policies, plans, and procedures for the performance of emergency functions with respect to the continuation or restoration of authorized programs of the Veterans' Administration under all conditions of national emergency, including attack upon the United States. These include:

> (1) The emergency conduct of inpatient and outpatient care and treatment in Veterans' Administration medical facilities and participation with the Departments of Defense and Health, Education, and Welfare as provided for in inter-agency agreements. . . ."

Interagency agreements were signed with DOD in 1965 and with DHEW (DHHS) in 1972 to coordinate planning and mutual support roles. The agreement with DOD established policies and directed planning to utilize VA facilities for military patients in support of a national emergency when the United States is not under attack. The agreement with DHEW was designed to ensure the maximum utilization of VA health resources *following an attack* "upon the United States" and to facilitate developing joint emergency operating plans and procedures.

Within the last two years efforts have been made to review and update these two agreements, and to establish operating procedures and coordinating systems. The need for this action has been made apparent in recent joint military civilian readiness exercises sponsored by the Federal Emergency Management Agency (FEMA).

In considering contingency planning legislation, we would call attention to the possibility that a major overseas war involving U.S. military forces (and VA facilities caring for battlefield casualties and new veterans) might also involve an attack on the United States. Under such circumstances, the FEMA might be called upon to coordinate national efforts. The VA would necessarily work with FEMA and other civil agencies in such contingencies.

The contingency medical backup of the VA to the military medical system has been of historic importance. It has, however, generally involved the acceptance of military personnel recently separated for medical disability. Others have been accepted on a space-available basis and returned to duty status.

The military medical system currently has a manifest need for increased combat casualty support. This legislation is designed to enhance the VA's contingency mission by upgrading the priority to VA care of the active duty casualty and giving VA flexibility to enter into long-range plans with DOD to furnish various levels of support.

Whether the VA should be formally charged with this responsibility is an issue with profound national security implications. While this issue is now undergoing review by this Administration, it involves multi-agency or department considerations and no final decision has yet been reached with respect thereto. Accordingly, we are not able at this time to take any formal position on H.R. 1969, nor to comment specfically on the various provisions of the measure.

Enactment of H.R. 1969 would not result in any immediate costs to the VA. Planning and testing associated with this proposal would require no additional resources, and the costs of activating the contingency system cannot be projected with any reliability until the need for those services arises.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Rufus H. Wilson,
Acting Administrator.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.
5001. Definitions.
5002. Acquisition of medical facilities.
5003. Authority to construct and alter, and to acquire sites for, medical facilities.
5004. Congressional approval of certain medical facility acquisitions.
5005. Structural requirements.
5006. Construction contracts.
5007. Reports to congressional committees.
5008. Contributions to local authorities.
5009. Garages and parking facilities.
5010. Operation of medical facilities.
[5011. Use of Armed Forces facilities.]
5011. Sharing of Veterans' Administration and Armed Forces facilities.
5012. Partial relinquishment of legislative jurisdiction.
5013. Property formerly owned by National Home for Disabled Volunteer Soldiers.
5014. Use of federally owned facilities; use of personnel.
5015. Acceptance of certain property.

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Subchapter I—Acquisition and Operation of Medical Facilities

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[§ 5011. Use of Armed Forces facilities]

§ 5011. Sharing of Veterans' Administration and Armed Forces facilities

(*a*) The Administrator and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, and material as may be needed to operate such facilities properly, **[**or for the transfer, without reimbursement of appropriations, of facilities, supplies, equipment, or material necessary and proper for authorized care for veterans,**]** except that at no time shall the Administrator enter into any agreement which will result in a permanent reduction of Veterans' Administration hospital **[**and domiciliary beds below the number established or approved on June 22, 1944**]**, *domiciliary, and nursing home beds below the number established or approved under section 5010 of this title,* plus the estimated number required to meet the load of eligibles under this title, or in any way subordinate or transfer the operation of the Veterans' Administration to any other agency of the Government.

(*b*)(*1*) *It is the sense of the Congress that there are opportunities for greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense which, if achieved, would be beneficial to both veterans and to members of the Armed Forces on active duty and which could result in reduced costs to the Government. Accordingly, the Administrator and the Secretary of Defense shall direct that the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, respectively, form an interagency committee to maintain oversight of opportunities for sharing of medical resources of the Veterans' Administration and the Department of Defense and to make recommendations to the heads of their respective agencies with respect to the sharing of those medical resources.*

(*2*) *In addition to such other duties as may be assigned to them in order to carry out this subsection, the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the "Assistant Secretary") shall regularly—*

(*A*) *assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;*

(*B*) *keep the other apprised of plans for any additional medical facilities planned by their respective agencies (including the location of new facilities and the acquisition of major new medical equipment) with regard to the impact of such plans on opportunities for interagency sharing;*

(*C*) *review the existing capabilities of the Veterans' Administration and of the Department of Defense with respect to direct health care (including support and administrative services) in order to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either the Veterans' Administration or the Department of Defense; and*

(*D*) *recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of the medical resources of the Veterans' Administration and the Department of Defense and to provide for coordinated planning for future development of the direct health care delivery systems of both the Veterans' Administration and the Department of Defense.*

(*3*) *In carrying out the duties prescribed by this subsection, the Assistant Secretary shall consult regularly with the Surgeons General of the Army, Navy, and Air Force.*

(*4*) *The Chief Medical Director and the Assistant Secretary may each* *carry out their respective functions under this subsection through any other official designated for such purpose.*

(c) Not later than one year after the date of the enactment of this subsection, and after considering the recommendations of the Chief Medical Director and the Assistant Secretary submitted under subsection (b) of this section, the Administrator of Veterans' Affairs and the Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. Such guidelines shall include provisions for the following:

(1) The director, in the case of a health care facility of the Veterans' Administration, or the medical or dental officer in charge, or the contract surgeon in charge, in the case of a health care facility under the jurisdiction of the Department of Defense shall, whenever possible, enter into cooperative sharing agreements with health care facilities of the other agency. Under any such agreement, an individual entitled to direct health care in a facility of one agency may be provided medical care at the facility of the other agency.

(2) Each agreement entered into pursuant to paragraph (1) of this subsection between the head of a facility of the Veterans' Administration and the head of a facility of the Department of Defense shall explicitly define the health care to be provided pursuant to such agreement. Services to be shared may include any medical resource, but the resources to be shared shall be negotiated and agreed upon by the heads of the facilities entering into the agreement.

(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the range of services, quality of care, or priority access for services of the primary beneficiaries of the providing agency.

(d)(1) Whenever a beneficiary receives medical services from a providing agency other than the providing agency for which such beneficiary is a primary beneficiary, the providing agency shall be reimbursed for the cost of the services provided based on any costing methodology agreed upon by the Administrator and the Secretary of Defense that is based on the cost of the services provided.

(2) Any reimbursement under paragraph (1) of this subsection shall be credited to the appropriation and to the facility that provided the services.

(e) The Administrator and the Secretary of Defense shall submit an annual joint report to Congress, to be submitted at the time the President's Budget for the next fiscal year is transmitted, with regard to—

(1) the guidelines prescribed pursuant to subsection (c) of this section;

(2) the opportunities for interagency sharing determined under subsection (b)(2) of this section;

(3) the interagency sharing agreements entered into by health-care facilities of the Veterans' Administration and the Department of Defense;

(4) the activities of the Veterans' Administration and the Department of Defense under such interagency sharing agreements;

(5) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

(6) the progress of Federal interagency medical resource sharing during the preceding fiscal year;

(7) the interagency coordination of Federal health resources planning;

(8) other major Federal activities to increase interagency sharing of Federal medical resources; and

(9) such legislative recommendations as they consider appropriate to facilitate interagency sharing of health care resources.

(f) For the purposes of this section:

(1) The term "direct health care" means health care provided to a beneficiary in a facility operated by the United States Government.

(2) The term "beneficiary" means a veteran who is entitled under this title to health care in Veterans' Administration facilities or a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

(3) The term "providing agency" means the Veterans' Administration or the Department of Defense.

(4) The term "primary beneficiary", with respect to the Veterans' Administration, means a veteran who is entitled under this title to health care in Veterans' Administration facilities, and, with respect to the Department of Defense, means a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

(5) The term "medical resource" means medical care resources and medical care support resources.

(g)(1) Notwithstanding section 5010(a) of this title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, as authorized by this section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

(2)(A) The Administrator may contract with private facilities for the provision by such facilities of hospital care and medical service described in subparagraph (B) of this paragraph during a period described in paragraph (1) of this subsection in which the President has authorized the Veterans' Administration to furnish priority medical care and services to members of the Armed Forces on active duty.

(B) Hospital care and medical services referred to in subparagraph (A) of this paragraph are—

(i) hospital care needed to treat a condition for which a veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition; and

(ii) hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of a

veteran eligible for such care or services under chapter 17 of this title, if Veterans' Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under paragraph (1) of this subsection.

(C) The Administrator shall prescribe regulations to govern contracting under this paragraph.

(D) The authority of the Administrator to enter into contracts undre this paragraph is subject to the availability of appropriations for that purpose.

(3) The cost of any care or service provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense and are based on the cost of the care or service provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided the care or service

(4) The Administrator and the Secretary of Defense may, without further review of such requests within the executive branch, submit requests to Congress (A) for relief from applicable personnel ceilings or other administrative restrictions, when such relief is needed in order to carry out this subsection, or (B) for appropriations to carry out this subsection.

(5) Within 30 days after an authorization by the President under paragraph (1) of this subsection for the Veterans' Administration to provide priority hospital care and services to members of the Armed Forces on active duty (or as soon after the end of such 30-day period as is reasonably practicable), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report of the Administrator's plan for the allocation of facilities and personnel in order to provide such care and services.

(6) During a period of war or national emergency described in paragraph (1) of this subsection, the Secretary of the military department concerned, upon the recommendation of the Administrator, may relieve any officer or employee of the Veterans' Administration whose duties concern the furnishing of care and services under chapter 17 of this title from any obligation to perform active military service which such officer or employee would otherwise be required to perform.

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97TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 97-72
Part 2

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE MEDICAL SHARING ACT

OCTOBER 27, 1981.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. **BRINKLEY**, from the Committee on Armed Services, submitted the following

REPORT

[To accompany H.R. 3502 which on May 7, 1981, was referred jointly to the Committee on Armed Services and the Committee on Veterans' Affairs]

[Including cost estimate of the Congressional Budget Office]

The Committee on Armed Services, to whom was referred the bill (H.R. 3502) to amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment (stated in terms of the page and line numbers of the introduced bill) is as follows:

Page 10, strike out line 6 and all that follows through line 6 on page 11 and insert in lieu thereof the following:

> (4) The Administrator shall maintain current plans for the provision of hospital care and medical services under this subsection to members of the Armed Forces on active duty. Such plans shall ensure that Veterans' Administration medical facilities are prepared to begin accepting members of the Armed Forces for such care and services as soon as practicable, and not more the 48 hours, after an authorization by the President under paragraph (1) of this subsection. Such plans shall be reviewed jointly by the Administrator and the Secretary of Defense not less often than annually, and any modification in such plans shall be

O 89-006

reported to the Committees on Veterans' Affairs and Armed Services of the Senate and House of Representatives within 30 days after such modification is agreed to.

EXPLANATION OF THE AMENDMENT

The amendment strikes language that would have—

(1) authorized the Veterans' Administration and the Department of Defense to submit requests directly to Congress without Executive Branch review for relief from personnel ceilings or for appropriations to carry out their responsibilities under this legislation, and

(2) authorized the Secretary of the military department concerned, during the period of war or national emergency, to relieve Veterans' Administration employees whose duties concern the furnishing of care and services under chapter 17 of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform.

The amendment also deletes the contingency planning and reporting provision of the bill and inserts in lieu thereof language that provides for long range pre-hostility planning and ensures that Veterans' Administration medical facilities would be prepared to accept members of the Armed Forces for treatment as soon as practicable, but not more than 48 hours following authorization by the President during a period of war or national emergency declared by the President or the Congress. The amendment further provides that such plans shall be reviewed jointly by the Administrator of the Veterans' Administration and the Secretary of Defense not less than annually with any modification reported to the Congress within 30 days after such change.

JOINT REFERRAL

The legislation was jointly referred to this committee and to the Committee on Veterans' Affairs because of shared jurisdiction under House Rule X.

The Veterans' Affairs Committee voted to favorably report the bill on May 12, 1981. See House Report 97-72, part I.

PURPOSE OF THE BILL

The purpose of H.R. 3502 is to amend title 38, United States Code, to provide for greater coordination and sharing of the medical resources of the Veterans' Administration and the Department of Defense and to provide medical care on a priority basis to members of the Armed Forces who are injured during a period of war or national emergency.

BACKGROUND AND DISCUSSION

In recent years, increasing concern has been expressed in the Congress over the rapidly escalating costs of health care in the private sector as well as in Federal facilities that provide direct health care to eligible beneficiaries. As a result of this concern, the National Health Planning and Resources Development Act of 1974 was enacted, requiring non-Federal hospitals to coordinate and plan the use of their medical resources. Soon after the enactment of this law, the General Accounting Office began an extensive examination of the possibilities for Federal hospitals to do the same.

GAO studies

On June 14, 1978, the General Accounting Office issued a report entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing." This study was based on a review of 50 of the 300 hospitals operated by the Veterans' Administration, the Department of Defense and the Public Health Service. Numerous opportunities for reducing Federal direct health care costs, now exceeding $10 billion a year, were identified as well as possibilities for improving the quality of health care through greater interagency sharing and coordination.

The General Accounting Office identified several legal and administrative obstacles blocking greater coordination and sharing between agencies and concluded that legislation was required to remove them. Among those obstacles are:

(1) Restrictive laws limiting the types of resources that can be shared between Federal agencies, and which beneficiaries can be treated in another agency's facility.

(2) Conflicting agency regulations, policies, and procedures. Most prominent are inconsistent and unequal reimbursement methods.

(3) Disincentives at the hospital director level. For example, when a Veterans' Administration hospital director agrees to provide a service to a Defense Department hospital, the reimbursement for that service goes to Washington rather than to the Veterans' Administration hospital providing the service.

(4) The absence of a specific legislative policy for interagency sharing.

The "Federal Health Resource Sharing Committee," (FHRSC) formed by the Department of Defense, the Veterans' Administration, and the Public Health Service verified the General Accounting Office's findings but was unable to implement many of the recommendations because of the obstacles in laws or regulations.

The General Accounting Office has reviewed the contingency planning of the Department of Defense for medical care for combat casualties and on June 26, 1980 issued a report entitled, "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System." The report found serious inadequacies in the existing contingency plans and their reliance on civilian hospitals.

GAO recommendation

The General Accounting Office has recommended that Congress enact legislation which would provide that both the Department of Defense and the Veterans' Administration fully participate in Federal medical planning for care of returning wartime casualties, and remove present legal and administrative barriers.

Congressional action

H.R. 3502, reported favorably by the Veterans' Affairs Committee on May 12, 1981, and jointly referred to the Committee on

Armed Services, is supported by both the Department of Defense and the Veterans' Administration. It is intended to overcome the many obstacles to such sharing that have been identified by the Department of Defense, the Veterans' Administration, the General Accounting Office and the Congress.

To accomplish this objective, H.R. 3502 would establish an interagency committee composed of the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs. The committee would be responsible for maintaining oversight of opportunities for sharing medical resources and for making recommendations to the Administrator and the Secretary of Defense on means to achieve that goal.

The bill is also designed to foster joint contingency planning between the two agencies. The Veterans' Administration health care systerm would be used as the primary backup to the Department of Defense health care system for treatment of U.S. military personnel engaged in armed conflict during a period of war or national emergency declared by the President or the Congress. Active duty members of the Armed Forces would be accorded special priority, second only to the priority of service-connected veterans, for care and treatment.

The committee believes that this legislation will contribute to the achievement of the major objectives of resource sharing and joint contingency planning, while at the same time improving health care and producing significant cost savings.

In hearings before the Subcommittee on Military Installations and Facilities on June 25, 1981, Department of Defense and Veterans' Administration witnesses supported H.R. 3502 with certain changes.

The committee amendment

The committee amendment to H.R. 3502 incorporates the changes proposed by the Department of Defense and the Veterans' Administration. The amendment accomplishes the following changes in the bill as referred to the Armed Services Committee:

(1) Deleted a provision that would authorized the Veterans' Administration and the Department of Defense, without Executive Branch review, to submit requests directly to Congress for relief from personnel ceilings or for appropriations to carry out their responsibilities under this legislation.

The committee believes this provision would be an unwarranted intrustion into the authority of the Executive Branch.

(2) Eliminated the provision that would authorize the Secretary of the military department concerned, during the period of war or national emergency, to relieve Veterans' Administration employees whose duties involve the furnishing of care and services under chapter 17 of title 38 United States Code (defines care and services as hospital, nursing home, or domiciliary care and medical treatment) from any obligation to perform active military service which such employee would otherwise be required to perform.

The committee deleted this provision because the reserve medical forces are an indispensable element of the total defense posture.

Department of Defense witnesses testified that medical reserves are at an alarmingly low level with some units having only 30 percent of the physicians' billets filled. The services would be especially dependent upon ready reservists in an early deployment situation.

The committee believes strongly that the 9,400 ready reservists (including non-medical) currently working for the Veterans' Administration should not be exempt from their obligation to report to active duty during a period of war or national emergency.

The service Secretaries already have the authority to excuse from callup any individual reservist if it is determined by the service Secretary that his or her services are better utilized in another area.

(3) Clarified the contingency planning provision of the original bill since it could be interpreted as allowing at least a 30-day delay subsequent to the initiation of hostilities before Veterans' Administration hospitals would be capable of accepting active duty casualties for treatment. Substitute language adopted would provide that the Administrator shall maintain current plans for the provision of hospital care and medical services to ensure that Veterans' Administration medical facilities are prepared to accept members of the Armed Forces as soon as practicable, and not more than 48 hours following authorization by the President during a period of war or a national emergency declared by the President or the Congress. Further, such plans would be reviewed jointly by the Administrator and the Secretary of Defense not less often than annually, and any modification would be reported to the Committees on Veterans' Affairs and Armed Services of the Senate and House of Representatives within 30 days after such change is agreed to.

It is anticipated that a very significant number of Armed Forces casualties would be generated immediately upon initiation of an armed conflict. This situation could occur within 48 hours following the start of a war or during a national emergency declared by the President or the Congress. It is possible that acute medical care and services beyond those available within the Department of Defense medical facilities would be immediately required. The committee believes that long-range pre-hostility planning to enable immediate (within 48 hours) utilization of Veterans' Administration hospitals for Armed Forces casualties is required.

MAJOR PROVISIONS OF H.R. 3502 AS AMENDED

Interagency committee

H.R. 3502 would direct the establishment of an interagency committee, composed of the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, to maintain oversight of opportunities for sharing medical resources and to make recommendations to the Administrator and the Secretary of Defense with respect to the sharing of such medical resources.

Committee duties

The duties assigned to this interagency committee would include the following:

(a) Assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;

(b) Keep each other apprised of plans for any additional medical facilities, including the acquisition of major new medical equipment, and of the impact of such plans on opportunities for interagency sharing;

(c) Review existing capabilities of the VA and DOD to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either agency; and

(d) Recommend to the Administrator and the Secretary of Defense policies and procedures to implement the provisions of this bill.

Guidelines for agency sharing

In carrying out these duties, and, after considering the recommendations of the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs, the Administrator and the Secretary of Defense would be required to jointly establish guidelines for the sharing of medical resources within one year after the date of enactment of the bill. Such guidelines would be required to include the following provisions:

(a) that the individual facility director or the officer in charge may enter into cooperative sharing agreements;

(b) that individuals entitled to direct health care in a facility of one agency may, pursuant to an explicitly defined agreement, be provided medical care at a facility of the other agency;

(c) that each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and not adversely affect the range of services, quality of care, or priority access for services to primary beneficiaries of the providing agency; and

(d) that reimbursement for such services would be based on the actual cost of the services rendered; and such reimbursements would be credited to the appropriation of the specific facility that provided the services.

Joint report

H.R. 3502 would call for an annual joint report to Congress, to be submitted at the time of the President's budget for the next fiscal year, with regard to sharing accomplishments during the preceding fiscal year, problems encountered, future plans and recommendations for additional legislative authority.

Treatment priorities

H.R. 3502 would establish a special priority for treating members of the Armed Forces during a period of war or national emergency second only to the priority of service-connected veterans for care and treatment.

Contract authority

This legislation would also provide special contract authority during such period of war or national emergency to permit the Administrator to furnish hospital care for veterans currently receiving out patient medical services under subsections 612 (f) and

(g) of title 38, United States Code, regarding the furnishing of medical services for disabilities on an out patient or ambulatory basis and the furnishing of medical services under other specified conditions on a reasonably necessary basis if delay in furnishing such hospital care would likely result in deterioration of the veterans' condition. Also, that contract authority would apply to hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing such care because of furnishing care to members of the Armed Forces under this new authority.

The measure would direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for use of the authority provided in the bill.

DEPARTMENTAL POSITION

The Department of Defense and the Veterans' Administration in letters dated September 24, 1981, and October 2, 1981, endorsed enactment of H.R. 3502 contingent upon suggested amendments. The committee has incorporated those amendments in the bill as reported.

The Office of Management and Budget interposed no objection to presentation of the reports for consideration by the committee.

The letters follow:

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,
Washington D.C., October 2, 1981.

Hon. MELVIN PRICE,
Chairman, Committee on Armed Services,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on H.R. 3502, 97th Congress, the "Veterans' Administration and Department of Defense Medical Sharing Act."

The purpose of the bill is to provide for greater coordination and sharing of the medical resources of the Veterans' Administration and the Department of Defense and to provide medical care on a priority basis to members of the Armed Forces who are injured during a period of war or national emergency.

This bill, by section 2, amends section 5011 of title 38, United States Code, to prescribe procedures to facilitate greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense. Achievement of these objectives of greater resources sharing will benefit both veterans and members of the Armed Forces on active duty and will likely result in lower costs to the Government from improved utilization of facilities and major medical equipments. The bill provides for the formation of an interagency committee by the joint action of the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs. This committee will be required to maintain oversight of opportunities for sharing of medical resources of both agencies, and to provide recommendations to the heads of their respective agencies for improved sharing of such medical resources.

The Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs will regularly: (1) assess opportunities for sharing, (2) keep each other informed of new facilities and major medical equipment planned for procurement, (3) review present capabilities of each agency with regard to direct health care to identify further opportunities for sharing without degrading quality of care or priority to the primary beneficiaries of each agency, and (4) recommend to their respective agency heads new policies and procedures which will maximize the sharing of their respective medical resources. In accomplishing these tasks the Assistant Secretary of Defense for Health Affairs shall consult regularly with the Surgeons General of the Services.

Section 2 of the bill further directs that not later than one year after the date of enactment of the legislation, the Administrator of the Veterans' Administration and the Secretary of Defense, after considering the recommendation of their respective chief medical representatives on the committee, will establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. These guidelines shall include provisions for the establishment of cooperative sharing agreements between the heads of medical facilities of each agency so that, if approved by both parties, a person entitled to care in a facility of one agency may be provided medical care at the facility of the other agency. The prescribed agreement must explicitly define the health care to be provided under the agreement. The cooperative agreement made between facilities will ensure that care to non-primary beneficiaries will be on a referral basis, and will not affect the quality, range of services, or priority of care rendered to the primary category of beneficiaries (as defined later in the legislation).

The legislation provides for reimbursement of costs incurred for medical services provided to beneficiaries of the other agency based on any costing methodology that is based on the cost of the services provided and is agreed upon by the Administrator of the Veterans' Administration and the Secretary of Defense. Such reimbursements shall be credited to the appropriation and to the facility that provided the medical services.

The legislation then provides for an annual report to be submitted to the Congress at the time of the President's Budget by the heads of the concerned agencies to include information on progress and achievements made during the past year in meeting all of the aforementioned medical resources sharing objectives. This annual report would also include information on other interagency activities directed toward maximizing the efficient use of Federal health resources, sharing of such resources, interagency coordination in planning, and legislative recommendations to improve future sharing of health care resources. The proposed legislation provides definitions for specific important terms used in the earlier text.

This bill would eliminate certain statutory constraints on the Veterans' Administration that inhibit the Administrator from fully supporting the Department of Defense in establishing an effective secondary military casualty care system during time of war or national emergency. After authorization by the President, the Administrator of Veterans' Affairs would give priority to the furnishing of medical care to members of the Armed Forces on active duty second only to veterans having service-connected disabilities.

It would permit the Administrator of Veterans' Affairs, when authorized to do so by the President, to give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty than to other persons eligible for such care and services with the exception of veterans with service-connected disabilities.

The bill would permit the Administrator to contract with private facilites in order to insure that Veterans who are entitled to medical services under subsection (f) or (g) of section 612 of title 38, and who are eligible for such care or services under chapter 17 of this title, are afforded such services in order to prevent any deterioration of a medical condition when services are not available through the Veterans' Administration because that agency is furnishing care and services to members of the Armed Forces.

The bill specifies that the cost of any care or services provided by the Veterans' Administration under paragraph (I) of this subsection shall be reimbursed by the Department of Defense at such a rate agreed upon by the Administrator and the Secretary of Defense.

The bill provides that the Veterans' Administration and the Department of Defense, without further review of such requests within the executive branch, would have authority to submit requests directly to Congress for relief from personnel ceilings or for appropriations to carry out the purposes of the bill.

The bill further indicates that within 30 days after an authorization by the President for the Veterans' Administration to provide priority hospital care and services to members of the Armed Forces on active duty (or as soon thereafter as practical) the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report of the Administrator's plan for the allocation of facilities and personnel in order to provide such care and services.

Finally, the bill provides that in a period of war or medical emergency . . . the Secretary of the military department concerned, upon the recommendation of the Administrator, may relieve any officer or employee of the Veterans' Administration whose duties concern the furnishing of care and services under chapter 17 of this title from any obligation to perform active military service which such officer or employee would otherwise be required to perform.

The Department of Defense supports the objectives of the proposed bill and has the following comments:

Section 2(d)(1), page 6. The Department of Defense supports the concept of offering incentives to providers at the medical facility level who engage in sharing arrangements. We therefore recommend that under such sharing arrangements, the providing agency be reimbursed for the cost of services provided, as negotiated by the directors or commanding officers of the participating health care facilities, and which are based upon guidelines agreed upon by the Administrator and the Secretary of Defense.

With regard to section 2(g), which would establish priority care during wartime or periods of armed conflict to members of the Armed Forces and when the Armed Forces are unable to furnish adequate care, we have the following objections:

Section 2(g)(4). We strongly object to this provision, which would permit agencies to request additional personnel and funds from the Congress in order to treat beneficiaries of other providing agencies. This would circumvent the President's administrative authority, and have the effect of eliminating personnel ceilings as a management tool to control Federal employment. We believe that personnel ceiling relief should be sought in the context of executive control over Federal employment, and that necessary funds should flow from the negotiated reimbursement agreement.

Section 2(g)(5). The Department is concerned with the provisions as stated as they might be interpreted as allowing at least a thirty day delay period subsequent to the initiation of hostilities before the Veterans' Administration would be capable of accepting active duty military casualties for treatment. It is anticipated that a very significant number of Armed Forces casualties would be generated immediately upon initiation of an armed conflict. This situation could occur within 48 hours following a declaration of war or national emergency by the President or the Congress. It is likely that acute medical care and services beyond those available within the Department of Defense medical facilities would be immediately required. Long range pre-hostility planning to enable immediate (within 48 hours) utilization of Veterans' Administration hospitals for Armed Forces casualties is required. A more desirable for section 2(g)(5) would be: "Within 180 days after enactment of this legislation, the Administrator of the Veterans' Administration, after consulting with the Secretary of Defense, will submit casualty care plans for injured active duty military members at Veterans' Administration medical facilities which could be implemented and fully functioning within 48 hours after the initiation of hostilities or other national disaster. These contingency planning reports will be submitted to the Committees on Veterans' Affairs and Armed Services of the Senate and House of Representatives. Such casualty care plans will be reviewed jointly at least annually by the Administrator of the Veterans' Administration and the Secretary of Defense, or their designees, and approved modifications or changes will be provided to the aforementioned Committees within 30 days of acceptance."

Section 2(g)(6). With regard to this section the Department opposes this portion of the bill because the Reserve medical forces are an indispensable element of our total defense posture. Members of the Reserve components employed by the Veterans' Administration must be required to meet all military service obligations to include their obligation to report to active duty. This is of concern to the Department of Defense since there are 9,400 Ready Reservists (including non-medical) currently working for the Veterans' Administration. This comprises 4.1 percent of the Veterans' Administration work force.

Subject to the comments noted above, we would favor enactment of sections 1 through 2(f) of H.R. 3502.

Cost and Budget Data

It is presently unknown how many beds could be made available by the Veterans' Administration within any particular time frame for the care of Armed Forces active duty personnel; therefore, any cost analysis of such service is not practical at this time. It is anticipated, however, that if H.R. 3502 is enacted that specific planning would begin from which cost estimates could be derived.

It would also be expected that an as yet underterminable savings of resources from better patient utilization of existing and planned facilities of both agencies would be realized.

The Office of Management and Budget advises that there is no objection to the presentation of this report and enactment of proposed section 2(g)(4) would not be in accord with the President's program.

Sincerely,

WILLIAM H. TAFT, IV.

SEPTEMBER 24, 1981.

Hon. MELVIN PRICE,
Chairman, Committee on Armed Services,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to your request for the views of the VA on H.R. 3502, a bill "To amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense."

The major purpose of this bill is to encourage and assist greater sharing of medical resources between the VA and the Department of Defense in order to benefit the primary beneficiaries of both agencies and which could result in reduced costs to the government. At the same time, it would also create a priority for care for active duty armed forces members in time of war or national emergency second only to the priority for service-connected veterans for care and treatment. Subject to several revisions discussed below, the VA favors the enactment of the provisions of this bill.

H.R. 3502 would mandate that the Secretary of Defense and the Administrator of Veterans Affairs direct the Assistant Secretary of Defense for Health Affairs and the Chief Medical Director respectively to form an interagency committee to assess jointly opportunities for sharing health resources between the VA and the DoD, to keep each other apprised of plans for establishing additional VA or DoD medical facilities and for the acquisition of major new medical equipment, and to identify sharing opportunities that will not adversely affect the quality or priority of care provided. This amendment would further require the two officials to recommend to their respective agency heads policies and procedures to maximize VA and DoD sharing of medical resources. In connection with these various duties, the amendment would also require that the Assistant Secretary of Defense for Health Affairs consult regularly with the Surgeons General of the Army, Navy and Air Force.

H.R. 3502 would mandate that the Administrator of Veterans Affairs and the Secretary of Defense within a year of its enactment jointly establish guidelines for the sharing of medical resources between VA and DoD medical facilities. These guidelines would authorize VA and DoD health care facility directors to enter into cooperative sharing agreements whenever possible.

Under the guidelines, these agreements would be negotiated between the heads of the facilities concerned and would explicitly define the health care to be provided under the agreement. Under the amendment's definitions, both veterans entitled to care in VA facilities and members and former members of the Army, Navy, Air Force or Marine Corps entitled to medical and dental care under title 10, United States Code, would be considered "primary beneficiaries of the respective agencies," and as such could be provided medical care under a sharing agreement.

The agreements would have to assure that the availability of direct health care for such beneficiaries be on a referral basis only, and that any such care rendered nonprimary beneficiaries would not adversely affect the range of services, quality of care, or priority access for service of the providing agency's primary beneficiaries. Reimbursement of the providing facility's costs, using any costing methodology based on the cost of the service provided, would be as agreed on by the Secretary of Defense and VA Administrator, and would be credited to the specific facility which provided the health care services.

The measure also calls for a VA-DoD annual joint report with regard to various aspects of the bill's implementation, to be submitted to the Congress as a whole at the time the President's Budget for the next fiscal year is transmitted.

Although the bill does not specifically so provide, it appears clear that the proposed joint responsibility of the Secretary of Defense and Administrator of Veterans Affairs as to uniform direct health care is neither intended to alter VA's or DoD's statutory responsibility with regard to providing medical services, nor to preclude the sharing of medical resources under any other law, except to the extent that it would amend 38 U.S.C. § 5011 to eliminate the authority of both the VA and the military department heads to transfer to the other "facilities, supplies, equipment or material" needed in the care of veterans without reimbursement of appropriations.

The VA is strongly committed to the concept of sharing and to the particular benefits of increased interagency sharing of medical resources between VA and DoD facilities. As a natural outgrowth of the differing statutes and missions relating to sharing, administrative interpretations of what constitutes acceptable sharing vary widely among agencies. In general, there are insufficient incentives and often clear disincentives militating against more interagency sharing. Much of this has been attributed to differing headquarters-level reimbursement mechanisms, and in some cases, to inefficient agency guidance in identifying sharing opportunities and implementing agreements. Although the VA has been active in initiating cross-servicing agreements under the Economy Act, reimbursement problems surrounding the sharing of medical services have been a major obstacle.

The Agency believes that distributing the amounts collected to the facility that generated the reimbursement would be helpful. The VA has specific authority in section 5053 of title 38, United States Code, to share specialized medical resources. "Specialized" medical resources are those which because of cost, limited availability, or unusual nature, are either unique in the medical community or are subject to maximum utilization only through mutual use.

Despite several limitations, improvements have occurred in the last few years in the sharing of specialized medical resources. These improvements include more awareness at Central Office level and at field activities of interagency resources, reduced processing time for gaining sharing agreement approval, and increased guidance to field activities on the mechanics of sharing medical resources.

The Agency finds the interagency sharing provisions of H.R. 3502 to be workable and sensitive to the needs of the VA, creating highly desirable incentives to *encourage* such sharing.

Central to achieving a health care system sensitive to and able to meet the needs of veteran beneficiaries is the independence to manage that system and plan its growth. The interagency sharing provisions of H.R. 3502, in our judgment, reflect a recognition of the importance of balancing the goal of greater interagency sharing with the commitments the VA and DoD have to their primary beneficiaries. In this connection, it should be clear that the type of resources to be shared, and the class of beneficiary to be treated, is best left to the discretion of the treating agency so as to avoid conflict with the primary mission of that agency.

The affinity and close association that would readily facilitate increased sharing between the VA and the military services is relatively unique. The VA would welcome the opportunity to build on and expand such sharing through the incentives that the interagency sharing authority in the bill would provide. In sum, the VA believes the language of that measure would satisfy the needs of both agencies and encourage and facilitate increased interagency sharing of medical resources between the Veterans Administration and the Department of Defense. The provisions would also maintain the integrity and separate health care missions of these provider agencies, and enhance their respective abilities to accomplish these missions in a cost-effective manner.

The VA has long provided needed medical care or resources for active duty military members, but neither our facilities nor our mission were designed to furnish general health care services to military dependents. While the VA could, under existing authority, furnish scarce medical services to any DoD beneficiary under a sharing agreement, we would oppose any proposal which would open the VA health care system at large to military dependents.

In essence, VA supports enactment of the sharing provisions of H.R. 3502 so long as any such legislation does not extend VA medical services to military dependents. Enactment of those provisions would not result in any costs to the VA.

H.R. 3502 would also formalize the role the Veterans Administration might play in planning and providing actual support for the Department of Defense in time of war or national emergency. This measure would establish a special priority for VA hospital care, nursing home care, and medical services for members of the Armed Forces on active duty during a period of war or a period of national emergency declared either by the President or the Congress. This priority would be second only to the priority of service-connected veterans for care and treatment.

It would also provide special contract authority during such a period of war or national emergency to permit the Administrator to furnish (1) hospital care for veterans currently receiving outpatient medical services under subsections (f) and (g) of section 612 of title 38, United States Code, if delay in furnishing such hospital care would be likely to result in deterioration of the veteran's condition, and (2) hospital care or medical services for veterans not currently receiving medical services for the treatment of a medical emergency which poses a serious threat to life or health of the veteran, if VA facilities are not capable of furnishing the care or services required because of furnishing care to members of the Armed Forces under this new authority.

H.R. 3502 would provide for DoD reimbursement to the VA at rates agreed upon by the administrator and the Secretary of Defense. Rates would be based on the cost of the care and service provided and reimbursements to the VA would be credited to the appropriations available to the VA facility providing the care or service. The measure also makes provision for reporting within 30 days after activation of this authority (or as soon thereafter as reasonably practicable), to the Veterans' Affairs Committees of the House and Senate regarding the Administrator's plan for the allocation of facilities and personnel to provide the required care and services.

The measure would also direct the Administrator and Secretary of Defense to enter into an agreement within 180 days after the date of enactment to pursue planning activities and to establish procedures and guidelines for the activation of this authority.

The contingency medical backup of the VA to the military medical system has been of historic importance. It has, however, generally involved the acceptance of military personnel recently separated for medical disabilities. Others have been accepted on a space-available basis and returned to duty status.

The military medical system currently has a manifest need for increased combat casualty support. This provision is designed to formalize the VA's contingency mission by upgrading the priority for VA care of the active duty casualty and giving VA flexibility to enter into long-range plans with DoD to furnish various levels of support.

The VA strongly supports the desirability of medical contingency planning between the Department of Defense and this Agency. Requirements in the law that VA facilities be maintained to ensure their availability for the treatment of the veteran, and that preference in providing medical services be given to various classes of veterans have, however, prevented us from committing the Agency to specific plans for participation in a civilian-military contingency hospital system.

Interagency agreements were signed with DoD in 1965 and with DHEW (DHHS) in 1972 to coordinate planning and mutual support roles. The agreement with DoD established policies and directed planning to utilize VA facilities for military patients in support of a national emergency when the United States is not under attack. The agreement with DHEW was designed to ensure the maximum utilization of VA health resources *following an attack* "upon the

United States" and to facilitate developing joint emergency operating plans and procedures.

Within the last two years, efforts have been made to review and update these two agreements and to establish operating procedures and coordinating systems. The need for this action has been made apparent in recent joint military civilian readiness exercises sponsored by the Federal Emergency Management Agency (FEMA).

While the VA has embarked on preliminary discussions with DoD to determine how our resources could best be utilized in a support rule, we believe that legislation such as H.R. 3502 would be needed to assure that VA could provide meaningful support to the Department.

Providing priority care to military personnel under such a contingency would necessarily displace certain eligible nonservice-connected veterans temporarily from access to care at VA medical centers involved in this effort. Although the VA does not favor the denial of care to any eligible veteran at any time, H.R. 3502 draws a reasonable line in providing the agency contract authority to assure continuity of care for those veterans under treatment and for others in need of emergency care. We believe that the limited exercise of this contract authority would be justified during a period of war or national emergency. The Agency believes military casualties should have a high priority claim on the limited VA resources that could be available at such a time. Accordingly, we believe special contract authority would permit the agency to respond flexibly in such an emergency situation.

The proposed new section 5011(g)(1) would empower the President to authorize the Adminstrator to extend higher priority for treatment to "members of the Armed Forces on active duty" than to other eligibles except veterans with service-connected disabilities. We understand this broader language to reflect an intention to leave to the Adminstrator and Secretary of Defense determinations as to the kinds of medical cases to be referred to the VA. Such determinations would be addressed in detailed guidelines to be developed under this proposal.

While we favor legislation to meet the purposes of H.R. 3502, we oppose the following two provisions and urge their deletion. We strongly oppose proposed new section 5011(g)(4), which would authorize, without Executive branch review, requests to Congress for relief from personnel ceilings or for appropriations to carry out this emergency authority. That proposal represents an unwarranted intrusion into the prerogatives of the President and the Executive Branch. This Administration and any Administration would request on a swift and timely basis any additional funds or personnel necessary to meet emergency requirements. We also oppose the provision which would authorize the Secretary of the military department concerned, during the period of war or national emergency, to relieve VA employees whose duties concern the furnishing of care and services under chapter 17 of title 38 from any obligation to perform active military service which such employee would otherwise be required to perform.

Enactment of the provisions of H.R. 3502 would not result in any immediate costs to the VA. Planning and testing associated with this proposal would require no additional resources, and the costs of activating the contingency system cannot be projected with any reliability, until the need for those services arises.

The Office of Management and Budget has advised that there is no objection to the presentation of this report and that enactment of proposed new section 5011(g)(4) would not be in accord with the President's program.

Sincerely,

ROBERT P. NIMMO, *Administrator.*

COMMITTEE POSITION

The Committee on Armed Services on October 22, 1981, agreed to report H.R. 3502, as amended, by voice vote.

FISCAL DATA

Pursuant to the House rules, the five-year cost projection of the legislation as estimated by the Department of Defense, the Veterans' Administration, the Committee on Armed Services, and the Congressional Budget Office follow:

DEPARTMENTAL COST ESTIMATE

The Department of Defense and the Veterans' Administration believe there will be no cost to the government associated with enactment of this legislation.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

In compliance with clause 2(1)(3)(C) of rule XI of the House of Representatives, the estimate prepared by the Congressional Budget Office and submitted pursuant to section 403 of the Congressional Budget Act of 1974 is included hereafter:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., October 22, 1981.

Hon. MELVIN PRICE,
Chairman, Committee on Armed Services,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 3502, the "Veterans' Administration and Department of Defense Medical Sharing Act", as ordered reported by the House Armed Services Committee on October 22, 1981.

Based on this review, it is expected that no additional cost to the government would be incurred as a result of enactment of this legislation.

Sincerely,

ALICE M. RIVLIN, *Director.*

COMMITTEE COST ESTIMATE

Pursuant to clause 7, rule XIII of the Rules of the House of Representatives, the committee attempted to determine outlays resulting from the bill for fiscal year 1982 and the four following fiscal years.

The committee concurs with the estimates of the Congressional Budget Office, the Department of Defense, and the Veterans' Administration that the legislation would result in no additional cost to the government.

INFLATION-IMPACT STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the committee examined the possible inflationary impact of the bill. It is the belief of the committee that the enactment of this legislation will not have an inflationary impact on the economy of the United States.

OVERSIGHT FINDINGS

With reference to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the committee has not received a report from the Committee on Government Operations in regard to this matter.

With reference to clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee finds and recommends that the legislation be enacted pursuant to its oversight responsibilities.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

SUBCHAPTER I—ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.
5001. Definitions.
5002. Acquisition of medical facilities.
5003. Authority to construct and alter, and to acquire sites, for medical facilities.
5004. Congressional approval of certain medical facility acquistions.
5005. Structural requirements.
5006. Construction contracts.
5007. Reports to congressional committees.
5008. Contributions to local authorities.
5009. Garages and parking facilities.
5010. Operation of medical facilities.
[5011. Use of Armed Forces facilities.]
5011. Sharing of Veterans' Administration and Armed Forces facilities.
5012. Partial relinquishment of legislative jurisdiction.
5013. Property formerly owned by National Home for Disabled Volunteer Soldiers.

Sec.
5014. Use of federally owned facilities; use of personnel.
5015. Acceptance of certain property.

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Subchapter I—Acquisition and Operation of Medical Facilities

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§ 5011. [Use of Armed Forces facilities] *Sharing of Veterans' Administration and Armed Forces facilities*

(*a*) The Administrator and the Secretary of the Army, the Secretary of the Air Force, and the Secretary of the Navy may enter into agreements and contracts for the mutual use or exchange of use of hospital and domiciliary facilities, and such supplies, equipment, and material as may be needed to operate such facilities properly, [or for the transfer, without reimbursement of appropriations, of facilities, supplies, equipment, or material necessary and proper for authorized care for veterans,] except that at no time shall the Administrator enter into any agreement which will result in a permanent reduction of Veterans' Administration hospital [and domiciliary beds below the number established or approved on June 22, 1944], *domiciliary, and nursing home beds below the number established or approved under section 5010 of this title,* plus the estimated number required to meet the load of eligibles under this title, or in any way subordinate or transfer the operation of the Veterans' Administration to any other agency of the Government.

(b)(1) It is the sense of the Congress that there are opportunities for greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense which, if achieved, would be beneficial to both veterans and to members of the Armed Forces on active duty and which could result in reduced costs to the Government. Accordingly, the Administrator and the Secretary of Defense shall direct that the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, respectively, form an interagency committee to maintain oversight of opportunities for sharing of medical resources of the Veterans' Administration and the Department of Defense and to make recommendations to the heads of their respective agencies with respect to the sharing of those medical resources.

(2) In addition to such other duties as may be assigned to them in order to carry out this subsection, the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the "Assistant Secretary") shall regularly—

(A) assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;

(B) keep the other apprised of plans for any additional medical facilities planned by their respective agencies (including the location of new facilities and the acquisition of major new medical equipment) with regard to the impact of such plans on opportunities for interagency sharing;

(C) review the existing capabilities of the Veterans' Administration and of the Department of Defense with respect to direct

health care (including support and administrative services) in order to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either the Veterans' Administration or the Department of Defense; and

(D) recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of the medical resources of the Veterans' Administration and the Department of Defense.

(3) In carrying out the duties prescribed by this subsection, the Assistant Secretary shall consult regularly with the Surgeons General of the Army, Navy, and Air Force.

(4) The Chief Medical Director and the Assistant Secretary may each carry out their respective functions under this subsection through any other official designated for such purpose.

(c) Not later than one year after the date of the enactment of this subsection, and after considering the recommendations of the Chief Medical Director and the Assistant Secretary submitted under subsection (b) of this section, the Administrator of Veterans' Affairs and the Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. Such guidelines shall include provisions for the following:

(1) The director, in the case of a health care facility of the Veterans' Administration, or the medical or dental officer in charge, or the contract surgeon in charge, in the case of a health care facility under the jurisdiction of the Department of Defense may enter into cooperative sharing agreements with health care facilities of the other agency. Under any such agreement, an individual entitled to direct health care in a facility of one agency may be provided medical care at the facility of the other agency.

(2) Each agreement entered into pursuant to paragraph (1) of this subsection between the head of a facility of the Veterans' Administration and the head of a facility of the Department of Defense shall explicitly define the health care to be provided pursuant to such agreement. Services to be shared may include any medical resource, but the resources to be shared shall be negotiated and agreed upon by the heads of the facilities entering into the agreement.

(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the range of services, quality of care, or priority access for services of the primary beneficiaries of the providing agency.

(d)(1) Whenever a beneficiary receives medical services from a providing agency other than the providing agency for which such beneficiary is a primary beneficiary, the providing agency shall be reimbursed for the cost of the services provided based on any costing methodology agreed upon by the Administrator and the Secretary of Defense that is based on the cost of the services provided.

(2) Any reimbursement under paragraph (1) of this subsection shall be credited to the appropriation and to the facility that provided the services.

(e) The Administrator and the Secretary of Defense shall submit an annual joint report to Congress, to be submitted at the time the President's Budget for the next fiscal year is transmitted, with regard to—

(1) the guidelines prescribed pursuant to subsection (c) of this section;

(2) the opportunities for interagency sharing determined under subsection (b)(2) of this section;

(3) the interagency sharing agreements entered into by health-care facilities of the Veterans' Administration and the Department of Defense;

(4) the activities of the Veterans' Administration and the Department of Defense under such interagency sharing agreements;

(5) other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

(6) the progress of Federal interagency medical resource sharing during the preceding fiscal year;

(7) the interagency coordination of Federal health resources planning;

(8) other major Federal activities to increase interagency sharing of Federal medical resources; and

(9) such legislative recommendations as they consider appropriate to facilitate interagency sharing of health care resources.

(f) For the purposes of this section:

(1) The term "direct health care" means health care provided to a beneficiary in a facility operated by the United States Government.

(2) The term "beneficiary" means a veteran who is entitled under this title to health care in Veterans' Administration facilities or a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

(3) The term "providing agency" means the Veterans' Administration or the Department of Defense.

(4) The term "primary beneficiary", with respect to the Veterans' Administration, means a veteran who is entitled under this title to health care in Veterans' Administration facilities, and, with respect to the Department of Defense, means a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

(5) The term "medical resource" means medical care resources and medical care support resources.

(g)(1) Notwithstanding any other provision of this title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and

medical services under chapter 17 of this title to members of the Armed Forces on active duty, as authorized by this section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

(2)(A) The Administrator may contract with private facilities for the provision by such facilities of hospital care and medical service described in subparagraph (B) of this paragraph during a period described in paragraph (1) of this subsection in which the President has authorized the Veterans' Administration to furnish priority medical care and services to members of the Armed Forces on active duty.

(B) Hospital care and medical services referred to in subparagraph (A) of this paragraph are—

(i) hospital care needed to treat a condition for which a veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition; and

(ii) hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care or services under chapter 17 of this title, if Veterans' Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under paragraph (1) of this subsection.

(C) The Administrator shall prescribe regulations to govern contracting under this paragraph.

(D) The authority of the Administrator to enter into contracts under this paragraph is subject to the availability of appropriations for that purpose.

(3) The cost of any care or service provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense and are based on the cost of the care or service provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided the care or service.

(4) The Administrator shall maintain current plans for the provision of hospital care and medical services under this subsection to members of the Armed Forces on active duty. Such plans shall ensure that Veterans' Administration medical facilities are prepared to begin accepting members of the Armed Forces for such care and services as soon as practicable, and not more than 48 hours, after an authorization by the President under paragraph (1) of this subsection. Such plans shall be reviewed jointly by the Administrator and the Secretary of Defense not less often than annually, and any modification in such plans shall be reported to the Committees on Veterans' Affairs and Armed Services of the Senate and House of Representatives within 30 days after such modification is agreed to.

* * * * * * *

SUMMARY

PURPOSE

The purpose of H.R. 3502 is to amend title 38, United States Code, to provide for greater coordination and sharing of the medical resources of the Veterans' Administration and the Department of Defense and to provide medical care on a priority basis to members of the Armed Forces who are injured during a period of war or national emergency.

FISCAL DATA

The Congressional Budget Office, the Department of Defense, and the Veterans' Administration agree that enactment of this legislation would result in no additional cost to the government. The committee concurs with that estimate.

DEPARTMENTAL POSITION

The Department of Defense and the Veterans' Administration recommend passage of H.R. 3502, as amended, and the Office of Management and Budget interposes no objection to its enactment.

COMMITTEE POSITION

The Committee on Armed Services on October 22, 1981, agreed to report H.R. 3502, as amended, by voice vote.

APPENDIX G

[From the Congressional Record, Vol. 127, No. 154, pp. S12249-S12264—Senate, Oct. 27, 1981]

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE HEALTH-CARE RESOURCES SHARING ACT

Mr. **BAKER**. Mr. President, I would inquire of the minority leader if he is in position to consider at this time calendar 288, S. 266.

Mr. **ROBERT C. BYRD**. Mr. President, that measure has been cleared on this side of the aisle.

Mr. **BAKER**. Mr. President, I ask the Chair to lay before the Senate Calendar No. 288, S. 266, the Federal interagency medical resources bill.

The **PRESIDING OFFICER**. The clerk will state the bill by title.

The legislative clerk read as follows: A bill (S. 266) to establish a Federal Inter-Agency Medical Resources Committee to insure the most efficient and effective use of Federal direct health care resources.

The Senate proceeded to consider the bill which had been reported from the Committee on Veterans' Affairs with an amendment to strike out all after the enacting clause and insert the following:

* * * * * * *

Mr. **SIMPSON**. Mr. President, I rise in support of S. 266, the proposed "Veterans' Administration and Department of Defense Health-Care Resources Sharing Act." S. 266 is designed to promote the coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense in order to reduce costs while improving access to health care for beneficiaries of each agency. In addition, it would establish the Veterans' Administration health-care system as the primary reserve to the Department of Defense for treatment of combat casualties.

Mr. President, I wish to take this opportunity to first describe the basic peacetime provisions of S. 266.

The Veterans' Administration, VA, health-care system includes 172 hospitals and the Department of Defense, DOD, operates 124 hospitals. In addition, the two agencies have numberous clinics and related facilities under their jurisdictions. In the past they have pursued their respective missions independently even when facilities of the two agencies were in geographic proximity.

Some local administrators have exchanged resources either informally or under existing legislative authority, but this has not been done on a systematic basis.

Mr. President, my esteemed colleague, Senator Charles H. Percy, has examined the possibilities for greater coordination and sharing of health-care resources as chairman of the Subcommittee on Energy, Nuclear Proliferation, and Government Processes. That committee has carefully reviewed Government Accounting Office, GAO, studies and held comprehensive hearings. The committee concluded that there is a tremendous potential for reducing Federal direct health care costs and enhancing the quality of care to beneficiaries through greater coordination among Federal providers, particularly the VA and DOD.

Subsequently, the Committee on Governmental Affairs reported out S. 266 which would establish an interagency committee to encourage the sharing of health-care resources, and which would provide appropriate incentives for such sharing.

Mr. President, S. 266 was sequentially referrred to the Committee on Veterans' Affairs, which shared Senator Percy's desire to improve the efficiency and effectiveness of Government programs.

However, the committee wanted to be certain that any modifications to the VA health-care system would not impair the agency's ability to meet its obligations to the veterans of this Nation.

After carefully reviewing the issue, the committee has determined that greater coordination and sharing of health-care resources between the VA and DOD has the potential for increasing access to services for veterans who neither live near a VA facility, nor near one which has the specialized services they might need.

In addition, sophisticated new equipment and technologies which might be too expensive for a single facility could become available to veterans on a shared basis.

The Veterans' Affairs Committee reported out an amendment in the nature of a substitute for S. 266, which I introduced. It retains Senator Percy's exemplary emphasis on improving Government operations while conforming to the procedure of establishing the appropriate VA implementing authorities in title 38, United States Code.

The first portion of this bill addresses the VA and DOD equally in providing a mandate for the coordination and sharing of their health-care resources. An interagency committee, under the direction of the chief medical officials of the two agencies, would be responsible for reviewing policies, assessing further opportunities for sharing, providing guidance, and engaging in related activities to foster effective interagency planning for resource utilization.

The remainder of the bill, Mr. President, would amend title 38 to authorize specific agency actions in support of the coordination and sharing of health-care resources.

After considering the recommendations of the interagency committee, the Administrator of Veterans' Affairs and the Secretary of Defense would establish guidelines for the sharing of health-care resources to the maximum extent feasible consistent with their respective responsibilities.

Such guidelines would contain provisions whereby the administrator of each VA and DOD health-care facility would be able to enter into sharing agreements for the provision of care or services to eligible beneficiaries of one agency at the other agency's facilities whenever feasible and appropriate.

Such agreements would allow the sharing of any health-care resources including administrative and support services as long as they identify explicitly the resources to be shared, the care to be provided, and the beneficiaries to be served.

Shared services would be provided on a referral basis as long as they did not adversely affect the range of services, quality of care, or priority for services provided to the primary beneficiaries of the host agency.

Reimbursement to the providing agency would be on the basis of local conditions, needs, and costs, and made to the facility which provided the care or services.

Sharing agreements would be subject to review and the opportunity for approval or disapproval by the chief medical officials of the two agencies.

Mr. President, in order to assist with congressional oversight of the program's implementation, the Administrator of Veterans' Affairs and the Secretary of Defense would be required to submit an annual report to Congress. It would contain information on the guidelines and their revision, the opportunities for coordination and sharing, a review of interagency activities and agreements, and legislative recommendations.

Mr. President, I would also like to briefly describe the contingency provisions incorporated in S. 266 by the Veterans' Affairs Committee.

The General Accounting Office has pointed out that there could be situations during war or a national emergency in which DOD would not have adequate health-care resources to meet the medical needs of combat casualties.

Although DOD has initiated contingency arrangements with several civilian hospitals, it is the judgment of this committee that the VA health-care system should be the principal backup health-care resource to the DOD in such critical situations.

Mr. President, as reported by the Committee on Veterans' Affairs, S. 266 would initiate contingency planning and provide special authorities for use only during a period of war or national emergency which involved the use of the Armed Forces in armed conflict. In such a situation, the Administrator would be able to give a higher priority for the furnishing of care and services to members of the Armed Forces on active duty than to any other eligible group with the exception of veterans with service-connected disabilities.

Furthermore, the Administrator could contract with private facilities to provide specified hospital care and medical services to certain groups of eligible veterans who otherwise might not be able to have urgent health-care needs met because of military pressures on the VA system.

The Administrator and the Secretary of Defense would be required to enter into an agreement to engage in planning for such medical contingencies and establish implementation procedures. Subsequent to any declaration of war or national emergency, the Administrator would report to the committees on the provision of priority care and services to members of the Armed Forces and on the use of the authority to contract with private facilities.

Mr. President, in concluding I wish to sincerely thank the distinguished ranking minority member from California, Senator Cranston, for his invaluable collaboration on this bill, and each of the other committee members who supported it unanimously.

In addition, I would like to recognize and to thank the very able members of the majority staff for their efforts. Kenneth Bergquist, former chief counsel and staff director, and his successor, Tom Harvey, and Julie Susman, Edward Kelty, Laurie Altemose, and our editorial director, Harold Carter, as well as members of the highly competent minority staff, Jonathan Steinberg, Edward Scott, and William Brew.

Mr. President, I believe the committees have reported out a bill which meets the concerns of the Committee on Governmental Affairs and the Committee on Veterans' Affairs. S. 266 addresses the efficiency and effectivenes of the VA and DOD health-care programs, the health-care needs of our veterans, and the preparedness requirements of our Armed Forces. On behalf of the entire committee, I urge the Senate's favorable consideration of this bill. Thank you, Mr. President.

Mr. **Cranston**. Mr. President, as the ranking minority member of the Committee on Veterans' Affairs, I am very pleased to support S. 266, the proposed Veterans' Administration and Department of Defense Health-Care Resources Sharing Act, as reported by the Committee on Veterans' Affairs on September 29. This measure addresses the appropriate relationship between the health-care resources of the Veterans' Administration and the Department of Defense both in peacetime and in time of war or national emergency involving armed conflict.

Mr. President, this legislation, as it is before the Senate today, is based on S. 266, introduced on January 27, 1980, by my good friend from Illinois (Mr. Percy), dealing with peacetime sharing as well as on a measure I introduced on June 9, 1981—amendment No. 62 to S. 636 dealing with both peacetime sharing and the VA's role as the principal backup for DOD in treating casualties of armed conflict.

The legislation I introduced was identical to the text of H.R. 3502, authored by my good friend from Mississippi (Mr. Montgomery), the chairman of the Veterans' Affairs Committee in the other body, as reported by that committee on May 10, 1981.

H.R. 3502 is now pending before the House Armed Services Committee, which ordered the bill reported on October 22. In submitting this legislation to the Senate, I noted that I did so with an open mind and was not committed to the precise formulations of that bill.

S. 266, as introduced, was originally referred to the Committee on Governmental Affairs and, following that committee's action on June 15, 1981, reporting the bill favorably, without amendments, S. 266 was referred to the Committee on Veterans' Affairs.

After a hearing on June 17, at which the Committee on Veterans' Affairs heard from a wide range of witnesses on both S. 266 and amendment No. 62 to S. 636, the Committee on Veterans' Affairs reported S. 266 with an amendment in the nature of a substitute that I proposed with our distinguished committee chairman (Mr. Simpson).

We sought in our substitute to meld together aspects of S. 266 as reported by the Governmental Affairs Committee and of amendment No. 62.

Mr. President, the Senator from Illinois (Mr. Percy) is to be congratulated for his great interest in and persistence on the issue of the sharing of VA and DOD health-care resources during peacetime. During our committee's consideration of this measure, it was suggested by administration representatives that there was no need for legislation to authorize the sharing of health-care resources between VA and DOD during peacetime because there is ample authority in current law.

One example that was cited in this regard was the general authority for interagency sharing contained in the Economy Act, 31 U.S.C. 666. Without resolving this point, I was persuaded by the Senator from Illinois (Mr. Percy) that the primary need for legislative action was not to establish new authority to share these resources but rather to remedy the lack of appropriate incentives for such sharing, to remove some disincentives to sharing, and to place a renewed statutory emphasis on sharing.

For these reasons, I was pleased to take the initiative in developing a measure that would help provide the needed incentives for and also remove the disincentives to peacetime sharing as well as authorize specifically the VA's role as backup for treating casualties of armed conflict. I believe that the pending measure meets these goals.

PEACETIME SHARING

Mr. President, I believe that increased emphasis on the sharing and coordination of health-care resources in peacetime between the VA and DOD is desirable in that it could lead to improved access to health care for the beneficiaries of the two agencies and, at the same time, result in economies in the operation of the two health-care systems through more efficient utilization of their resources.

However, it is my firm conviction that such sharing must not be permitted to have a detrimental impact on the ability of either of the two agencies to continue to provide quality health care to their respective beneficiaries under current law. The Veterans' Affairs Committee is, of course, the entity in the Senate charged with direct responsibility for legislation and oversight regarding the VA health-care system, and it is for this reason that I strongly urged that our committee have the opportunity to help shape this measure.

In this regard, Mr. President, I believe, and I hope the Senator from Illinois (Mr. Percy) would agree, that the measure as reported by the Veterans' Affairs Committee represents a fair approach to meeting the goals of S. 266 as reported by the Government Affairs Committee—to promote and foster increased cooperation and sharing of health-care resources between VA and DOD during peacetime—while recognizing and reaffirming the Va health-care system's primary role of providing timely, quality health care to beneficiaries eligible for care under the VA's basic health-care legislative authorities in title 38 of the United States Code.

Mr. President, the committee substitute—in a free-standing legislative provision not in title 38, but referred to by cross-reference in amendments to title 38 provisions later in the committee substitute—provides, as did S. 266 in a free-standing provision without any cross-references, for the establishment of an interagency committee, the Veterans' Administration/Department of Defense Health-Care Resources Coordinating Committee, that will be the principal body responsible for promoting increased coordination and sharing of health-care resources between the two agencies.

It is important to note, however, that this body, on which the two agencies' chief medical officers will serve as the principal members, is responsible only for developing strategy for increased coordination and sharing of resources.

Any implementation of such strategy will lie with the Administrator of Veterans' Affairs and the Secretary of Defense, and it is vital that these two officials become and remain active in the area of sharing.

Without such a commitment of attention and effort from the top, efforts of the VA/DOD Committee may not result in any real increase in sharing between the two agencies.

Conversely, if the Administrator and the Secretary commit themselves to increasing the level of VA/DOD cooperation and sharing with respect to health-care resources, I believe that the goals of this legislation can be realized.

Mr. President, I would like to make one further point with reference to making, as I just noted, the chief medical officers of the two agencies the principal members of the VA/DOD Committee. At the present time, the VA's Chief Medical Director is Dr. Donald L. Custis. Dr. Custis is a former Surgeon General of the Navy and, if this measure is enacted and the VA/DOD Committee is established, I believe that his presence as an initial member of that committee will prove to be highly beneficial to the committee's success.

I have the highest regard for Dr. Custis's efforts as the VA's chief medical director, and I know that he is very supportive of the basic thrust of this legislation and will be very sensitive to the needs and limits of the VA health-care system as he participates in developing new opportunities for sharing with DOD. At the same time, his experience as the chief health officer of one of the uniformed services gives him unique insights into the DOD health-care system that should further enhance his participation in developing a new emphasis on improved coordination and sharing of the resources of the two agencies.

Mr. President, I want to note how S. 266 as reported by the Committee on Veterans' Affairs addresses specifically two concerns about provisions in amendment No. 62 that were raised by the Senator from Illinois (Mr. Percy during his testimony before the Committee on Veterans' Affairs on June 17—namely, precluding the VA from treating military dependents under a sharing agreement and requiring that reimbursements between local facilities be based on uniform, standard rates.

On the issue of treating dependents under sharing agreements, the committee substitute authorizes each agency, pursuant to sharing agreements, to treat any statutory beneficiaries of the other agency that are specified in a particular sharing agreement.

This would allow VA facilities, where appropriate and desirable, to treat military dependents, and DOD, again where appropriate and desirable, to treat those VA dependents eligible for care and services under title 38.

In adopting this approach, the Committee on Veterans' Affairs did not intend to require any particular VA facility to provide care under a sharing agreement to any particular category of beneficiaries that could not be provided the needed care and services in the normal course of providing health-care services, but only to authorize the provision of care and services when and where consistent with a facility's capacity and capabilities.

Moreover, the committee was well aware of the strong opposition of the VA's Department of Medicine and Surgery and others to any use of VA health-care facilities to treat DOD dependents. Hence, under the committee substitute, this is a matter left entirely to the discretion of the two agencies to determine together; if the VA persists in its view on this issue, it can obviously prevail.

With reference to Senator Percy's second major concern, the reimbursement mechanism, the committee substitute would expressly authorize reimbursements to be made on the basis of locally determined formulas—developed in light of central guidance from the two agencies—which would be subject to approval by the chief medical officers of the two agencies. This approach should insure that local conditions and needs are taken fully into account in developing sharing agreements, including reimbursement formulas.

CARE FOR CASUALTIES OF ARMED CONFLICT

Mr. President, in addition to providing a renewed emphasis on the peacetime sharing of health-care resources between the VA and DOD, S. 266 as reported by the Committee on Veterans' Affairs contains amendments to title 38 relating to the appropriate relationship of the health-care resources of the two agencies in time of war or national emergency involving the use of our Armed Forces in armed conflict.

I review these provisions as very important, and I strongly urged that they be addressed in the context of the overall VA/DOD health-care resources relationships. I have long believed and stated that the VA should be the principal backup to the health-care resources of the Department of Defense in time of war or national emergency.

It has been very clear for a number of years that, in the event of major armed conflict, the Department of Defense would be unable to cope with more than a small percentage of the anticipated casualties from such a conflict—a point that was reaffirmed during the committee's June 17 hearing.

In my view, the firstline backup to DOD in such a situation should be the VA health-care system. It is a comprehensive, nationwide system, and there is a natural linkage between the two systems in that the beneficiaries of the DOD generally become the beneficiaries of the VA at some point, a result that frequently occurs after a member of the Armed Forces is disabled in service and is then medically discharged.

Mr. President, despite what seems to me an obvious role for the VA, DOD has been reluctant in the recent past, as contingency plans have been developed, to rely fully on the VA to fulfill this contingency role because of questions about the adequacy of the VA's authority under current law to treat combat casualties on a priority basis. Instead, DOD had been working to establish voluntary agreements with civilian hospitals across the country to provide contingency backup through a "Civilian-Military Contingency Hospital System." Although I agree that there is a role for civilian hospitals to play in this regard depending on the extent of the casualties, I believe that DOD should turn first to the VA, an assessment shared by the General Accounting Office, which, after reviewing the Civilian-Military Contingency Hospital System, issued a June 26, 1980, report entitled "The Congress Should Mandate Formation of a Military-VA-Civilian Contingency Hospital System."

Mr President, the committee substitute would provide a basis for the VA to fulfill this contingency role by expressly authorizing the agency, during a period of war or national emergency that involves the use of our Armed Forces in armed conflict, to provide the primary backup to DOD health-care facilities in rendering hospital care, nursing home care, and medical services to members of the Armed Forces on a higher priority basis than to any other group of individuals other than veterans with service-connected conditions.

The establishment of this new mission for the VA—together with provisions in H.R. 3499, legislation passed earlier this month which is now awaiting Presidential action, that would require the VA to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency—should remove any impediment to the VA's working closely with DOD to develop contingency plans and, in the tragic event that the agency's health-care resources are ever needed to support the DOD in time of war or national emergency, the mechanism should be in place to carry out such a supportive role.

Mr. President, in conjunction with this new authority, the pending measure would also authorize the Administrator, in situations in which the VA is treating Armed Forces personnel under the new authority, to contract with private health-care facilities to provide health care under certain circumstances to specified categories of veterans.

I believe that this is an important adjunct to the new contingency authority and demonstrates that, even in situations in which the agency is treating wartime casualties, there would be a continuing obligation to provide care for specified categories of veterans.

Mr. President, the specific provisions amending title 38 with respect to this contract eligibility and other aspects of the committee substitute are discussed in detail in the section-by-section analysis in the committee report—No. 97-196. The excerpts from the committee report that the committee chairman (Mr. Simpson) has inserted in the Record during his remarks on this bill include the section-by-section analysis, and I particularly call the attention of my colleagues to the description there of proposed new subsection (e) of section 5011 of title 38, as proposed to be added by section 4(a)(4) of the committee substitute.

CONCLUSION

Mr. President, I believe that S. 266, as it is before the Senate today, represents an appropriate reconciliation of the two approaches to the sharing of VA and DOD health-care resources that were encompassed in S. 266 as reported by the Committee on Governmental Affairs and amendment No. 62.

The pending measure should give the full emphasis on peacetime sharing between the two agencies that the Senator from Illinois (Mr. Percy) advocates while recognizing and respecting the separate missions and statutory authorities of the two agencies' health-care components.

The inclusion in this measure of the new contingency authority for the VA to treat the casualties of an armed conflict provides appropriate recognition of the fact that the relationship between the health-care resources of the two agencies should not be limited to peacetime efforts to reduce costs and eliminate duplication of effort but also must include a recognition that the VA can and should supplement DOD in those situations in which DOD cannot care for all the casualties of an armed conflict.

To the extent that peacetime sharing efforts may create pressure to reduce the capability or capacity of either agency, there will likely be a counterpressure to recognize and take action with respect to the need for the maintenance of health-care resources to care for battle casualties, and I believe that it is appropriate that these potentially competing concerns be addressed together, as in the pending measure.

Mr. President, I want to thank my good friend from Wyoming (Mr. Simpson) for his cooperation and assistance as we have worked together to develop the measure that is before the Senate today. We have enjoyed a very productive working relationship since he first came to the Senate and the committee at the beginning of the last Congress, and I am pleased that, although we have exchanged roles this Congress, that relationship has been maintained and strengthened.

I also want again to note the fine efforts of my good friend from Illinois (Mr. Percy) on this issue and express my appreciation for his assistance in insuring that the Committee on Veterans' Affairs has had an appropriate opportunity to review and work on this legislation.

I also want to express my appreciation to the members of the committee staff who have worked on this measure—particularly for the majority staff, Ed Kelty, a congressional fellow who has quickly grasped the many complex issues involved in the legislation and has worked with it throughout his tenure on the staff, and Julie Susman, and Bill Brew, Ed Scott, and Jon Steinberg on the minority staff.

Mr. President, I urge my colleagues to give this measure their unanimous approval.

Mr. THURMOND. Mr. President, I rise to strongly endorse S. 266, the Veterans' Administration and Department of Defense, Health-Care Resources Sharing Act, which is being considered today. The Committee on Veterans' Affairs held a hearing on this bill on June 17, 1981, and we have worked hard since then to prepare what I believe to be a meritorious legislative initiative.

Mr. President, the Veterans' Administration and the Department of Defense today both operate major health-care systems which serve many Federal beneficiaries.

These two health-care systems have operated in large part without coordinative efforts to reduce expenses through resource sharing. S. 266 will promote resource sharing while insuring that there are no adverse effects on the quality of care given to primary beneficiaries of either system.

Mr. President, I would like to take a moment to briefly outline the major provisions of this bill.

First, the bill will establish a committee to be known as the Veterans' Administration Department of Defense Health-Care Resources Coordination Committee, which will review existing sharing practices and policies, assess further opportunities for sharing, and provide guidance in implementing the purposes of the bill. The committee will be comprised of the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs and other employees they may designate.

Second, the bill will provide for the sharing of beds and health-care resources by the Veterans' Administration and the Department of Defense at their respective facilities.

Third, the bill provides that during wartime or national emergency, the Administrator of the Veterans' Administration may designate VA medical facilities to aid in the treatment of active members of the Armed Forces.

Mr. President, this bill represents a chance for us to reduce an area of Federal spending without reducing the quantity or quality of services now being provided. At the same time, we will enhance our defense posture by insuring our readiness to care for our casualties in time of war. For these reasons, I intend to support S. 266, and I urge my colleagues to do the same.

Mr. PERCY. Mr. President, we are asking many Americans to make sacrifices in our efforts to reduce Federal spending and balance the budget by 1984. In view of this, it is only fair that we make an unprecedented effort to ferret out waste, duplication, and inefficiencies in the operation, of all Government programs.

The Federal Interagency Medical Resources Sharing and Coordination Act of 1981, cosponsored by Senator Cohen, Senator Durenberger, Senator Proxmire, and Senator Simpson, will help put an end to the needless duplication that currently exists in the Veterans' Administration and Defense Department hospital systems. What is most unusual about this legislation, especially in these days of reduced Government services, is that it will save money and improve the quality of health care provided to Federal beneficiaries.

I originally introduced similar legislation last year, and the Senate unanimously approved hospital sharing legislation last September. Unfortunately, the House did not act on the proposal. This year, the House is moving quickly toward passage of similar legislation. I would like to thank Senator Simpson and Senator Cranston of the Veterans' Affairs Committee, as well as Senator Roth and Senator Eagleton of the Governmental Affairs Committee, for their support of S. 266. Because of their help, the bill was promptly considered and reported unanimously by these two committees in the Senate.

The Federal Government operates one of the largest health-care systems in the world at a cost of more than $12 billion annually. The Veterans' Administration operates 171 hospitals; the Defense Department maintains 129—these two agencies account for 95 percent of the Federal hospital system.

Last summer, I discovered that millions of dollars were being needlessly wasted, and access to quality care was being hindered, because these agencies are unable to share health-care facilities and personnel—such as hospital beds, medical equipment, and doctors. Even worse, they often plan new facilities, sometimes within blocks of each other, without considering consolidating their facilities and equipment to avoid duplication.

Mr. President, one of the worst examples of this practice is going on right now in my own State of Illinois. In North Chicago, the VA and Navy operate hospitals, less than a mile from each other. While the Navy's modern facility sits more than three-quarters empty because of a lack of doctors, forcing them to spend $3 million on private sector care, the VA nearby plans to spend millions in coming years on its crumbling 1905 era buildings. The VA, unlike the Navy, enjoys a relative abundance of doctors. Current laws, regulations, and other problems have blocked all attempts to coordinate these expensive resources among the two Federal facilities.

For lack of a VA-Army agreement to share Boston VA orthopedic services, the Army flies dozens of patients from Boston to Walter Reed Hospital in Washington on its very expensive air evacuation system, when more convenient and less costly treatment could be provided by the VA.

These are just two examples of costly duplication in the Federal Government's health care programs. The General Accounting Office has estimated that, although 202 of the VA and DOD hospitals lend themselves to some form of coordination in 73 locations, little sharing or planning exists.

Why do not these agencies share? There are legal obstacles preventing efficient use of Federal hospitals. For instance, a VA patient cannot be transferred to a Navy bed. Also, military dependents, entitled to Federal care, cannot be treated in a VA hospital—regardless of whether the VA doctors have time to see them. In addition, there are clear disincentives mitigating against greater cross agency sharing. For example, when a local VA hospital agrees to provide a service to a Defense Department facility, the funds reimbursed for that service go to Washington rather than to the providing hospital. Whereas, if that same hospital buys that service from a private hospital, where costs may be four times higher to the taxpayer, they get reimbursed directly. Thus, we are forcing Government to buy medical services at a higher price outside the Government, before looking to other agencies that may have available care.

The consequences of this lack of coordination by the VA and DOD reach beyond the millions of dollars wasted and impeded access to care for some Federal beneficiaries.

If war were to break out tomorrow, there would not be a contingency plan for returning wounded to use VA hospital beds. In fact, there is some doubt as to whether the VA would have statutory authority to treat combat casualties.

The purpose of S. 266 is simple: clear away the legal and administrative barriers to sharing, create incentives at the local level, and encourage the agencies to begin assessing moneysaving and care-enhancing opportunities for sharing, and implement them expeditiously. Also, it will allow the Veterans' Administration to treat incoming combat casualties in case of war.

Because of the important obligation that we have to those who have served their country. I have insisted throughout the deliberations over this bill that specific safeguards be included to prohibit sharing where it would adversely affect the quality of, or established priority access to, direct health care by veterans. We will not turn our backs on the many veterans who have given so much to keep this country free. This legislation will only enhance the quality of care provided veterans, and other Federal beneficiaries.

Reaction to the bill has been nearly unanimous—this legislation is needed. Perhaps the GAO put it best when they said:

The enactment of (this legislation) would represent a significant step forward in which federal agencies could make the most cost-effective use of their medical resources while maintaining, or perhaps enhancing, the quality of care provided to their many beneficiaries.

UP AMENDMENT NO. 543

Mr. **Baker**. Mr. President, I send to the desk an amendment on behalf of the Senators from Indiana and ask for its immediate consideration.

The **Presiding Officer**. The clerk will report.

The legislative clerk read as follows:

The Senator from Tennessee (Mr. Baker), for Mr. Lugar and Mr. Quayle, proposes an unprinted amendment numbered 543.

Mr. **Baker**. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The **Presiding Officer**. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place in the bill add a new section:

Sec. —. That the Veterans' Administration medical center located at 1481 West 10th Street, Indianapolis, Indiana, shall hereafter be known and designated as the "Richard L. Roudebush Veterans' Medical Center". Any reference to such medical center in any law, regulation, document, map, record, or other paper of the United States shall be deemed to be a reference to the Richard L. Roudebush Veterans' Medical Center.

Mr. **Quayle**. Mr. President, I wish to express my strong support of the amendment to S. 266, offered by the majority leader, which would designate the Veterans' Administration Medical Center in Indianapolis, Ind., as the "Richard L. Roudebush Veterans' Medical Center." I understand the amendment has been cleared with both the Committee on Governmental Affairs and the Committee on Veterans' Affairs.

On September 15, 1981, my colleague from Indiana, Senator Lugar, and I joined in introducing a bill to provide this deserved recognition to a fellow Hoosier, Richard Roudebush.

There certainly is no controversy over this legislation and by attaching it to S. 266 we hope to accomplish this honor for Rowdy at the earliest possible time.

Dick Roudebush has been so strongly identified with veterans and veterans organizations for so many years that it is highly appropriate that the veterans' medical center in the capital city of his native Indiana bear his name.

"Rowdy" served in the U.S. House of Representatives for 10 years, and then made an unsuccessful bid for the U.S. Senate.

In 1971 he was named Director of the Congressional Relations Office of the Veterans' Administration. Subsequently, he served as Deputy Administrator for the VA, and President Ford appointed him Administrator in October 1974.

He proved to be an able, efficient, and effective leader of the Veterans' Administration.

This small effort to honor the contributions of Dick Roudebush for his service to our Nation and to the cause of veterans has the strong endorsement of the major veterans organizations. Incidentally, "Rowdy" was the first World War II veteran to be named commander of his local VFW post in 1948. He continued his dedication and service to VFW through various important positions and in 1957 was elected national VFW commander in chief.

Today, Mr. President, Dick Roudebush is working back on his farm in Noblesville, Ind., but he continues to be keenly interested and involved in community and national affairs. He remains a patriot of the first order.

I urge the adoption of this amendment.

The **Presiding Officer**. The question is on agreeing to the amendment of the Senator from Tennessee.

The amendment (UP No. 543) was agreed to.

UP AMENDMENT NO. 544

Mr. **Baker**. Mr. President, I send another amendment to the desk on behalf of Mr. Simpson and Mr. Cranston, and I ask for its immediate consideration.

The **Presiding Officer**. The clerk will report.

The legislative clerk read as follows:

The Senator from Tennessee (Mr. Baker), for Mr. Simpson and Mr. Cranston, proposes an unprinted amendment numbered 544.

Mr. **Baker**. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The **Presiding Officer**. Without objection, it is so ordered.

The amendment is as follows:

On page 21, after line 13, insert the following new section:

Sec. 5. (a) Section 1786(a)(1) of title 38, United States Code, is amended by striking out "Each" and inserting in lieu thereof "Notwithstanding any other provision of law unless enacted in express limitation of this subsection, each".

(b) The amendment made by this section shall take effect as of October 1, 1981.

Mr. **Cranston**. Mr. President, I rise in support of the pending amendment which I am offering along with the distinguished chairman of the Veterans' Affairs Committee (Mr. Simpson) that would provide for the continuation of entitlement to GI bill benefits for correspondence training at the level agreed to in the Omnibus Budget Reconciliation Act of 1981—now Public Law 97-35—and that is offered in order to signify that if the entitlement to this benefit is to be terminated or restricted it should not be done through the appropriations process but rather through the authorization process and to make clear that, in any event, it should be done clearly and unequivocally.

As Members may recall, the Senate and House Veterans' Affairs Committees and, upon their recommendations, the Congress very recently acted in the context of legislation within our committee's jurisdiction to reduce the correspondence training entitlement. Pursuant to reconciliation instructions in House Concurrent Resolution 115, the first concurrent resolution on the budget for fiscal year 1982, to recommend legislative savings for veterans' programs by $110 million, the members of the two Veterans' Affairs Committees agreed in the context of negotiations on the Omnibus Budget Reconciliation Act of 1981 to reduce from 70 to 55 percent of the established charges the amount of the allowance that the VA will pay for correspondence lessons completed and submitted after September 30, 1981, and to eliminate, effective October 1, 1981, GI bill benefits for flight training for veterans not enrolled in such training on August 31, 1981.

These provisions were estimated to save $17.3 million in fiscal year 1982—$14.1 million in connection with the elimination of flight training and $3.2 million in connection with the modification of the entitlement to correspondence training—and were signed into law on August 13, 1981, as sections 2003 and 2004 respectively, of the Omnibus Budget Reconciliation Act of 1981.

Shortly thereafter, on September 11, the conferees on H.R. 4034, the Hud-Independent Agencies Appropriations Act for fiscal year 1982, filed the conference report on that measure (H. Rept. No. 97-222) containing a proviso to the appropriations for the VA's readjustment benefits account stating that—"This appropriation is hereby reduced by $19,700,000 through the elimination of payments for flight and correspondence training benefits, except for those persons enrolled in flight training on August 31, 1981, and correspondence training on September 30, 1981, and who remain continuously thereafter so enrolled and meet the applicable requirements of eligibility."

The amount of the purported reduction in this provision is $2.4 million more than the savings estimated to result from the two GI bill changes made by the Reconciliation Act.

This conference report was passed by the House on September 15 but has not been acted on by the Senate. However, section 101(e) of the continuing resolution—House Joint Resolution 325, signed into law as Public Law 97-51 on October 1—provided that provisions of that conference report were incorporated into the continuing resolution—"to the extent and in the manner provided for in the conference report and joint explanatory statement of the Committee of Conference . . . as if such act had been enacted into law."

Mr. President, as my good friend from the other body, the chairman of the House of Representatives Committee on Veterans' Affairs (Mr. Montgomery), pointed out during the debate in the other body on the conference report, and as I reiterated in endorsing these points during consideration of the continuing resolution on September 24, this proviso is highly questionable in form and substance in light of the title 38 provisions providing eligible veterans with entitlement to the GI bill benefits involved. For the reasons Congressman Montgomery expressed during the debate on the conference report—Congressional Record H6202-03, daily edition, September 15, 1981—I do not believe that the Congress, in passing the continuing resolution, intended to repeal the entitlement that Vietnam-era veterans have under title 38, United States Code, to benefits for the pursuit of correspondence training.

As the chairman noted on September 15, section 1786(a)(1) of title 38 provides clearly that any eligible veteran—"who enters into an enrollment agreement to pursue a program of education exclusively by correspondence shall be paid an educational assistance allowance computed at the rate of 55 percent of the established charge which the institution requires non-veterans to pay for the course or courses pursued by the eligible veteran."

Section 1661(a) of title 38 states that such a veteran "shall be entitled" to educational assistance for a specified period of time up to 45 months.

Thus, the GI bill benefit paid to eligible Vietnam-era veterans enrolled in approved correspondence courses is unquestionably an entitlement under title 38—a view also expressed in a September 30 opinion of the VA General Counsel's Office. That benefit is in no sense discretionary, as are some other VA benefit programs. If a veteran meets the eligibility requirements regarding service under this provision of law, and enters into an enrollment agreement with a school to pursue a program of education through correspondence training, the law directs the Administrator to pay an educational assistance allowance not to exceed the rate established by law.

In light of the questions arising from the relationship between the legislative changes made in the Reconciliation Act and the proviso included by reference in the continuing resolution, the VA is, pending further guidance from the Congress, holding in suspension new applications of veterans wishing to use their GI bill benefits for correspondence training.

Mr. President, I ask that the legal opinion I referred to earlier and an October 2, 1981, memorandum from the VA's Acting General Counsel to the Chief Benefits Director on this subject be printed in the Record at this point.

The material follows:

MEMORANDUM, OCTOBER 2, 1981

"To Chief Benefits Director.

"Subject: Correspondence Training.

"1. As you are aware, the Congress, in enacting the Omnibus Reconciliation Act (Pub. L. No. 97-35), provided that effective October 1, 1981, section 1786 of title 38, United States Code, was to be amended to reduce the reimbursement rate for correspondence training from 70 percent to 55 percent.

"2. As you are also aware, the House-Senate Conferees on the HUD-Independent Agencies Appropriation Act, provided that effective October 1, 1981, no funds would be available for correspondence training courses except for those individuals enrolled in correspondence training on September 30, 1981, and who remain continuously thereafter so enrolled and meet the applicable requirements of eligibility.

"3. A question has arisen as to whether or not the subsequent enactment of program restrictions in an appropriation measure has the effect of limiting program entitlements. For that reason, we requested a legal opinion by PSG-IV concerning this matter. A copy of their opinion is attached for your information.

"4. In the enactment of the continuing resolution (HJRes. 325), the Congress provided that the amounts of money and the conditions set forth in the conference report on the HUD appropriation measure would govern VA authority for spending under the continuing resolution. Thus, in view of that language, the VA would be subject to the correspondence limitation cited above. The appropriation measure has not, of course, been finally adopted by the Congress and sent to the President. Therefore, the possibility still remains that a further change could be made in the language presently contained in the conference report. Nevertheless, in light of the provisions in the continuing resolution, we would suggest that you may wish to consider issuing instructions to your regional offices to the effect that any new applications for correspondence training received after September 30, 1981, be held pending final resolution of this problem.

"ROBERT E. COY,
Acting General Counsel."

MEMORANDUM, SEPTEMBER 30, 1981

"To: Assistant General Counsel.

"Subject: Readjustment Benefits (RB) Appropriation Language Limiting Payment of Flight and Correspondence School Benefits.

"1. You have asked our opinion as to the VA's authority to pay educational assistance benefits to veterans enrolling in flight and correspondence schools after October 1, 1981, the beginning of fiscal year 1982. It is our understanding that Pub. L. No. 97-35 altered the entitlement of these veterans by repealing 38 U.S.C. §1677 (flight training) and amending 38 U.S.C. §1786(a)(1) (reducing reimbursement to correspondence trainees from 70 percent to 55 percent effective October 1, 1981.) However, the Conference Report on H.R. 4034, the fiscal year 1982 HUD-Independent Agencies Appropriation Act, includes the following proviso in the Readjustment Benefits (RB) account language:

"'*Provided*, That this appropriation is hereby reduced by $19,700,000 through the elimination of payments for flight and correspondence training benefits, except for those persons enrolled in flight training on August 31, 1981, and correspondence training on September 30, 1981, and who remain continuously thereafter so enrolled and meet the applicable requirements of eligibility.'

"2. The 'savings' clause of the appropriation language pertaining to flight training corresponds substantially with the language of section 2006(b) of Pub. L. No. 97-35. The effect is that both title 38 and the appropriation language prohibit payment to veterans who enroll in flight training after September 30, 1981, unless they had previously enrolled by August 31, 1981. However, veterans who enroll in correspondence school after October 1, 1981, appear to be eligible for benefits under 38 U.S.C. §1786, while the RB appropriation language would apparently bar payments to these individuals.

"3. At the present time, this matter is further confused by the reluctance of the Congress to forward H.R. 4034 to the President. As an interim measure, the Senate has proposed that the following language be inserted in H.J. Res. 325, the continuing resolution authorizing funding for all agencies for fiscal year 1982:

"'(e) Notwithstanding any other provision of the joint resolution, except section 102, such amounts as may be necessary for projects or activities provided for in the Department of Housing and Urban Development-Independent Agencies Appropriations Act, 1982 (H.R. 4034), at a rate of operations and to the extent and in the manner provided for in the conference report and joint explanatory statement of the Committee of Conference (H. Rept. No. 97-222) filed in the House of Representatives on September 11, 1981, as if such Act had been enacted into law.'

"It is the Senate's intent that the VA operate its programs within the limits provided for in the conference version of H.R. 4034, which includes the limitation on flight and correspondence benefits quoted above.

"4. While we are aware that an argument could be made that the language of the continuing resolution does not constitute a repeal of the VA's authority to make payments to new enrollees in correspondence courses, it is our opinion that this argument is legally insufficient. We believe that the conferees on the VA's appropriation bill clearly intended to prohibit payment to new enrollees in correspondence courses. The same Committee in the Senate offered the language quoted above as an amendment to the continuing resolution when it became apparent that H.R. 4034 would not be enacted into law by October 1, 1981. The language is susceptible to varying interpretations, but we think it is apparent that the intent of the Senate is to prohibit payment to any person enrolling in a correspondence course after September 30, 1981.

"5. Although time constraints have not permitted us to examine this issue in depth, we conclude that the VA will have no authority to make payments to these individuals during the period when the continuing resolution is in effect. If H.R. 4034 is enacted with substantially the same language that was agreed to by the conference committee, the same conclusion would be applicable to fiscal year 1982.

It should be expressly noted that we have not reached any conclusion with regard to the question of whether the language of H.R. 4034 or the continuing resolution constitutes a repeal of the entitlement to such benefits.

"'It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute. *United States* v. *Vulte*, 233 U.S. 509, 34 S.Ct. 664, 58 L.Ed. 1071 (1914); *Ralston* v. *United States*, 91 Ct.Cl. 91 (1940), cert. denied, 311 U.S. 687, 61 S.Ct. 65, 85 L.Ed. 444, involving a lack of appropriations to pay a naval officer his retired pay and allowances pursuant to a special act placing him on the retired list. The failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims, *Gibney* v. *United States*, 114 Ct.Cl. 38, 51, 52 (1949); *Leonard* v. *United States*, 80 Ct.Cl. 147 (1935); *New York Central R. R.* v. *United States*, 65 Ct.Cl. 115, 128 (1928), aff'd 279 U.S. 73, 49 S.Ct. 260, 73 L.Ed. 619 (1929); *Danford* v. *United States*, 62 Ct.Cl. 285 (1926); *Strong* v. *United States*, 60 Ct.Cl. 627, 630 (1925); *Ferris* v. *United States*, 27 Ct.Cl. 542, 546 (1892).' *New York Airways* v. *United States*, 369 F.2d 743, 748 (Ct.Cl. 1966).

"It is our opinion that the likelihood of litigation on this issue would be greatly reduced if the Congress took steps which have been suggested by the Chairman of the House Committee on Veterans Affairs in the Congressional Record (127 Cong. Rec. H6202-03 (daily ed. Sept. 15, 1981) (remarks of Mr. Montgomery) (copy attached)). In the absence of such steps, we will receive an opinion on this issue for another time.

"6. If you have any questions about this matter, please contact Patrick Ryan at extension 5017.

"NEAL C. LAWSON,
Assistant General Counsel."

Mr. CRANSTON. Mr. President, in my view, if GI bill benefits for correspondence training are to be further reduced or terminated or, indeed, if any changes in a title 38 entitlement program are to be made—legislative action to achieve the desired results should be taken in a measure under the jurisdiction of the Veterans' Affairs Committees. It is not an appropriate function of the Appropriations Committees to propose in appropriations bills that entitlements under current law be terminated or reduced.

Mr. President, this amendment would amend the entitlement provision in title 38, section 1786(a)(1), to provide that such entitlement would continue in effect—"[n]otwithstanding any other provision of law unless enacted in express limitation of [this section] . . . ."

This "notwithstanding" reference is specifically designed to supersede or eliminate the effectiveness of any appropriations rider or other enactment—including the proviso incorporated by reference to H.R. 4034 in the continuing resolution—unless such rider or enactment—whether previously or subsequently enacted—expressly limits or alters the entitlement in section 1786(a) of title 38 by making specific reference to that provision.

Therefore, in addition to providing for the continuation of GI bill benefits for correspondence training in fiscal year 1982 as agreed to by Congress and enacted only 2 months ago in the Reconciliation Act, this amendment stands for the proposition that if this entitlement is to be terminated or restricted it should not be done through the appropriations process but rather through the authorization process and that, if that is to be done, it should be done clearly and unequivocally by specific reference to the title 38 entitlement provision.

As I noted, Mr. President, this amendment would be consistent with the viewpoint expressed by Chairman Montgomery on the House floor—and in which I concurred during the Senate's consideration of the continuing resolution on September 25—that—"Legislated entitlements cannot be repealed by indirection or imprecise riders suggesting that the funds were not appropriated by the Congress for a vaguely defined purpose."

At that time, I also stated: "Those remarks seem even more apt in light of the once-removed nature of the action now being taken by this body with respect to that conference report."

The amendment is also consistent with the statement of my distinguished colleague from Wyoming (Mr. Simpson) who, as chairman of the Senate Veterans' Affairs Committee, noted during the Senate's consideration of the Continuing Resolution that he did—"not support this action of the conferees, taken unilaterally in disregard of the legislative plans so carefully worked out by both the House and Senate Veterans' Affairs Committees. . . ."

Mr. President, I am very grateful to the distinguished committee chairman for his cooperation in joining with me in this measure to carry out the will of Congress under the Reconciliation Act regarding GI bill benefits for correspondence training, to remove the uncertain legal status regarding the availability of and entitlement to these benefits, and to express and signify emphatically the disposition of the Senate in terms of the appropriate division of responsibilities between the authorization and appropriations processes.

Mr. President, I urge the Senate to approve this amendment.

The amendment (UP No. 544) was agreed to.

Mr. **Hart**. Mr. President, the chairman of the Senate Veterans' Affairs Committee is correct. I had intended to offer an amendment, which would incorporate the provisions of S. 349, the Veterans' Administration's Administrative Procedure and Judicial Review Act, to S. 266. The Veterans' Affairs Committee did hold hearings on S. 349 in July and had on two occasions scheduled committee meetings to consider the bill. Unfortunately, both those sessions were canceled.

Mr. President, the provisions of S. 349 are identical to legislation which passed the Senate unanimously last session. I have for some time supported this legislation, first introduced in the 94th Congress, a bill to reform the administrative procedures of the Veterans' Administration and allow for judicial review of certain final decisions by the Veterans' Administration. I believe S. 349 to be an excellent bill that reflects several years of diligent work by the Senate Veterans' Affairs Committee and its staff in consultation with me and my staff.

I have consulted with Senator Simpson and believe we have reached an acceptable compromise which will allow S. 266 to be considered without further delay.

Mr. **Simpson**. Mr. President, as the Senator from Colorado knows, I have scheduled a committee meeting for the 25th of November to consider S. 349.

Mr. **Hart**. Mr. President, understanding that the new chairman of the Senate Veterans' Affairs Committee would like an opportunity to thoroughly review the provisions of S. 349, I appreciate his commitment to hold the markup on S. 349 on the 25th of November. It is further my understanding that his intention is to move the measure to the floor in an expeditious manner.

Mr. **Simpson**. Mr. President, the Senator is correct. When the measure is marked up, I expect to recommend that it be expeditiously considered by the committee. I also would intend to work for its expeditious consideration by the Senate.

I know of the strong concern and hard work Senator Hart has put into his legislation and appreciate his longstanding concern for the rights of the American veteran.

Mr. **Baker**. Mr. President, I ask unanimous consent that a summary of S. 266 as reported be printed in the Record.

There being no objection, the sumary was ordered to be printed in the Record, as follows:

* * * * * * *

Mr. **Baker**. Mr. President, I move to reconsider the vote by which the bill was passed.

Mr. **Robert C. Byrd**. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The title was amended so as to read:

A bill to foster greater coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense, and to amend title 38, United States Code, to authorize appropriate coordination and sharing of such health-care resources.

APPENDIX H

[From the Congressional Record, Vol. 128, No. 36, pp. S3348–S3359—Senate, April 1, 1982]

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE MEDICAL SHARING ACT

Mr. BAKER. Madam President, I am prepared now to proceed to the consideration of the House message on S. 266, and if there is no objection from the minority, I will proceed to that at this time.

Mr. ROBERT C. BYRD. Madam President, there is no objection.

Mr. BAKER. Madam President, I ask that the Chair lay before the Senate a message from the House of Representatives on S. 266.

The Presiding Officer laid before the Senate the following message from the House of Representatives:

Resolved, That the bill from the Senate (S. 266) entitled "An Act to foster greater coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense, and to amend title 38, United States Code, to authorize appropriate coordination and sharing of such health-care resources: and for other purposes", do pass with the following amendments:

Strike out all after the enacting clause, and insert: That this Act may be cited as the "Veterans' Administration and Department of Defense Medical Sharing Act".

SEC. 2. (a) Section 5011 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "The Administrator";

(2) by striking out "or for the transfer" and all that follows through "care for veterans.";

(3) by striking out "and domiciliary beds below the number established or approved on June 22, 1944" and inserting in lieu thereof ", domiciliary, and nursing home beds below the number established or approved under section 5010 of this title"; and

(4) by adding at the end the following:

"(b)(1) It is the sense of the Congress that there are opportunities for greater sharing and coordination of the medical resources of the Veterans' Administration and the Department of Defense which, if achieved, would be beneficial to both veterans and to members of the Armed Forces on active duty and which could result in reduced costs to the Government. Accordingly, the Administrator and the Secretary of Defense shall direct that the Chief Medical Director of the Veterans' Administration and the Assistant Secretary of Defense for Health Affairs, respectively, form an interagency committee to maintain oversight of opportunities for sharing of medical resources of the Veterans' Administration and the Department of Defense and to make recommendations to the heads of their respective agencies with respect to the sharing of those medical resources.

"(2) In addition to such other duties as may be assigned to them in order to carry out this subsection, the Chief Medical Director and the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the 'Assistant Secretary') shall regularly—

"(A) assess the opportunities for sharing of existing medical resources between the Veterans' Administration and the Department of Defense;

"(B) keep the other apprised of plans for any additional medical facilities planned by their respective agencies (including the location of new facilities and the acquisition of major new medical equipment) with regard to the impact of such plans on opportunities for interagency sharing;

"(C) review the existing capabilities of the Veterans' Administration and of the Department of Defense with respect to direct health care (including support and administrative services) in order to identify opportunities for sharing that will not adversely affect the quality of, or the established priority of, care provided by either the Veterans' Administration or the Department of Defense; and

"(D) recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of the medical resources of the Veterans' Administration and the Department of Defense.

"(3) In carrying out the duties prescribed by this subsection, the Assistant Secretary shall consult regularly with the Surgeons General of the Army, Navy, and Air Force.

"(4) The Chief Medical Director and the Assistant Secretary may each carry out their respective functions under this subsection through any other official designated for such purpose.

"(c) Not later than one year after the date of the enactment of this subsection, and after considering the recommendations of the Chief Medical Director and the Assistant Secretary submitted under subsection (b) of this section, the Administrator of Veterans' Affairs and the Secretary of Defense shall jointly establish guidelines for the sharing of medical resources by health care facilities of the Veterans' Administration and the Department of Defense. Such guidelines shall include provisions for the following:

"(1) The director, in the case of a health care facility of the Veterans' Administration, or the medical or dental officer in charge, or the contract surgeon in charge, in the case of a health care facility under the jurisdiction of the Department of Defense may enter into cooperative sharing agreements with health care facilities of the other agency. Under any such agreement, an individual entitled to direct health care in a facility of one agency may be provided medical care at the facility of the other agency.

"(2) Each agreement entered into pursuant to paragraph (1) of this subsection between the head of a facility of the Veterans' Administration and the head of a facility of the Department of Defense shall explicitly define the health care to be provided pursuant to such agreement. Services to be shared may include any medical resource, but the resources to be shared shall be negotiated and agreed upon by the heads of the facilties entering into the agreement.

"(3) Each such agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not, as determined by the directors or commanding officers participating in such arrangements, adversely affect the range of services [illegible] quality of care, or priority access for services of the primary beneficiaries of the providing agency.

"(d)(1) Whenever a beneficiary receives medical services from a providing agency other than the providing agency for which such beneficiary is a primary beneficiary, the providing agency shall be reimbursed for the cost of services provided based on any costing methodology agreed upon by the Administrator and the Secretary of Defense that is based on the cost of the services provided.

"(2) Any reimbursement under paragraph (1) of this subsection shall be credited to the appropriation and to the facility that provided the services.

"(e) The Administrator and the Secretary of Defense shall submit an annual joint report to Congress, to be submitted at the time the President's Budget for the next fiscal year is transmitted, with regard to—

"(1) the guidelines prescribed pursuant to subsection (c) of this section;

"(2) the opportunities for interagency sharing determined under subsection (b)(2) of this section;

"(3) the interagency sharing agreements entered into by health-care facilities of the Veterans' Administration and the Department of Defense;

"(4) the activities of the Veterans' Administration and the Department of Defense under such interagency sharing agreements;

"(5) the other interagency activities directed toward maximizing the efficient use of Federal health resources during the preceding fiscal year;

"(6) the progress of Federal interagency medical resource sharing during the preceding fiscal year;

"(7) the interagency coordination of Federal health resoures planning;

"(8) other major Federal activities to increase interagency sharing of Federal medical resources; and

"(9) such legislative recommendations as they consider appropriate to facilitate interagency sharing of health care resources.

"(f) For the purpose of this section:

"(1) The term 'direct health care' means health care provided to a beneficiary in a facility operated by the United States Government.

"(2) The term 'beneficiary' means a veteran who is entitled under this title to health care in Veterans' Administration facilities or a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

"(3) The term 'providing agency' means the Veterans' Administration or the Department of Defense.

"(4) The term 'primary beneficiary', with respect to the Veterans' Administration, means a veteran who is entitled under this title to health care in Veterans' Administration facilities, and, with respect to the Department of Defense, means a member or former member of the Army, Navy, Air Force, or Marine Corps who is entitled to medical and dental care under section 1074 of title 10.

"(5) The term 'medical resource' means medical care resources and medical care support resources.

"(g)(1) Notwithstanding any other provision of this title, during a period of war, or a period of national emergency declared by the President or the Congress which involves the use of the Armed Forces of the United States in armed conflict, the Administrator, when authorized to do so by the President, may give a higher priority to the furnishing of hospital care, nursing home care, and medical services under chapter 17 of this title to members of the Armed Forces on active duty, as authorized by this section, than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

"(2)(A) The Administrator may contract with private facilities for the provisions by such facilities of hospital care and medical service described in subparagraph (B) of this paragraph during a period described in paragraph (1) of this subsection in which the President has authorized the Veterans' Administration to furnish priority medical care and services to members of the Armed Forces on active duty.

"(B) Hospital care and medical services referred to in subparagraph (A) of this paragraph are—

"(i) hospital care needed to treat a condition for which a veteran is receiving medical services under subsection (f) or (g) of section 612 of this title, in any case in which delay in furnishing such hospital care would, in the judgment of the Administrator, be likely to result in deterioration of that condition; and

"(ii) hospital care or medical services for the treatment of a medical emergency which poses a serious threat to the life or health of a veteran eligible for such care or services under chapter 17 of this title, if Veterans' Administration facilities are not capable of furnishing the care or services required because of the furnishing of care and services to members of the Armed Forces under paragraph (1) of this subsection.

"(C) The Administrator shall prescribe regulations to govern contracting under this paragraph.

"(D) The authority of the Administrator to enter into contracts under this paragraph is subject to the availability of appropriations for that purpose.

"(3) The cost of any care or service provided by the Veterans' Administration under paragraph (1) of this subsection shall be reimbursed to the Veteran's Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense and are based on the cost of the care or service provided. Amounts received under this paragraph shall be credited to appropriations available to the Veterans' Administration facility which provided the care or service.

"(4) Not later than the end of the 180-day period beginning on the date of the enactment of the Veterans' Administration and Department of Defense Medical Sharing Act, the Administrator and the Secretary of Defense shall enter into an agreement under which the Administrator and the Secretary shall agree to pursue planning activities and to establish procedures and guidelines under which this subsection shall be carried out. Not later than the end of the 365-day period beginning on the date of the enactment of such Act, the Administrator and the Secretary of Defense shall complete plans for the provision of hospital care and medical services under this subsection to members of the Armed Forces on active duty and shall submit such plans to the Committees on Veterans' Affairs and on Armed Services of the Senate and House of Representatives. Such plans shall be reviewed jointly by the Administrator and the Secretary of Defense not less often than annually, and any modification in such plans shall be reported to the Committees on Veterans' Affairs and on Armed Services of the Senate and House of Representatives within 30 days after such modification is agreed to.

"(5) Within 30 days after an authorization by the President under paragraph (1) of this subsection for the Veterans' Administration to provide priority hospital care and services to members of the Armed Forces on active duty (or as soon after the end of such thirty-day period as is reasonably practicable), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report of the Administrator's allocation of facilities and personnel in order to provide such care and services.".

(b)(1) The heading of such section is amended to read as follows:

"§ 5011. Sharing of Veterans' Administration and Armed Forces facilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 is amended to read as follows:

"5011. Sharing of Veterans' Administration and Armed Forces facilities.".

Amend the title so as to read: "An Act to amend title 38, United States Code, to provide for greater coordination and sharing of the medical facilities of the Veterans' Administration and the Department of Defense.".

UP AMENDMENT NO. 871

Mr. BAKER. Madam President, I move that the Senate concur in the House amendments with a further Senate amendment which I send to the desk on behalf of the Senator from Wyoming (Mr. SIMPSON) and the Senator from California (Mr. CRANSTON).

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Tennessee (Mr. BAKER), for Mr. SIMPSON and Mr. CRANSTON, proposes an unprinted amendment numbered 871.

Mr. BAKER. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

In lieu of the matter proposed to be inserted by the amendment of the House to the text of the bill, insert the following:

That this Act may be cited as the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act".

SEC. 2. (a) The Congress makes the following findings:

(1) There are opportunities for greater sharing of the health-care resources of the Veterans' Administration and the Department of Defense which would, if achieved, be beneficial to both veterans and members of the Armed Forces and could result in reduced costs to the Government by minimizing duplication and underuse of health-care resources.

(2) Present incentives to encourage such sharing of health-care resources are inadequate.

(3) Such sharing of health-care resources can be achieved without a detrimental effect on the primary health-care beneficiaries of the Veterans' Administration and the Department of Defense.

(b) The Congress makes the following further findings:

(1) During and immediately after a period of war or national emergency involving the use of the Armed Forces of the United States in armed conflict, the Department of Defense might not have adequate health-care resources to care for military personnel wounded in combat and other active-duty military personnel.

(2) The Veterans' Administration has an extensive, comprehensive health-care system that could be used to assist the Department of Defense in caring for such personnel in such a situation.

SEC. 3. (a) Section 5011 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "The Administrator" the first place it appears;

(2) by striking out "and material" and all that follows through "this title," and inserting in lieu thereof "material, and other resources as may be needed to operate such facilities properly, except that the Administrator may not enter into an agreement that would result (1) in a permanent reduction in the total number of authorized Veterans' Administration hospital beds and nursing home beds to a level below the minimum number of such beds required by section 5010(a)(1) of this title to be authorized, or (2) in a permanent reduction in the total number of such beds operated and main-

tained to a level below the minimum number of such beds required by such section to be operated and maintained"; and

(3) by adding at the end the following new subsections:

"(b)(1) In order to promote the sharing of health-care resources between the Veterans' Administration and the Department of Defense (hereinafter in this section referred to as the 'agencies'), there is established an interagency committee to be known as the Veterans' Administration/Department of Defense Health-Care Resources Sharing Committee (hereinafter in this subsection referred to as the 'Committee').

"(2) The Committee shall be composed of—

"(A) the Chief Medical Director and such other officers and employees of the Veterans' Administration as the Chief Medical Director may designate; and

"(B) the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the 'Assistant Secretary') and such other officers and employees of the Department of Defense as the Assistant Secretary may designate,

except that the size of the Committee shall be mutually determined by the Chief Medical Director and the Assistant Secretary. During fiscal years 1982 and 1983, the Chief Medical Director shall be the chairman of the Committee. During fiscal year 1984, the Assistant Secretary shall be the chairman of the Committee. Thereafter, the chairmanship of the Committee shall alternate each fiscal year between the Chief Medical Director and the Assistant Secretary. The agencies shall provide administrative support services for the Committee at a level sufficient for the efficient operation of the Committee and shall share the responsibility for the provision of such services on an equitable basis. "(3) In order to enable the Committee to make recommendations under paragraph (4) of this subsection, the Committee shall on a continuing basis—

"(A) review existing policies, procedures, and practices relating to the sharing of health-care resources between the agencies;

"(B) identify and assess further opportunities for the sharing of health-care resources between the agencies that would not, in the judgment of the Committee, adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency;

"(C) identify changes in policies, procedures, and practices that would, in the judgment of the Committee, promote such sharing of health-care resources between the agencies;

"(D) monitor plans of the agencies for the acquisition of additional health-care resources, including the location of new facilities and the acquisition of major equipment, in order to assess the potential impact of such plans on further opportunities for such sharing of health-care resources; and

"(E) monitor the implementation of activities designed to promote the sharing of health-care resources between the agencies.

"(4) Within nine months of the date of the enactment of this subsection and at such times thereafter as the Committee considers appropriate, the Committee shall make recommendations to the Administrator or the Secretary of Defense, or both, with respect to (A) changes in policies, procedures, and practices that the Committee has identified under paragraph (3)(C) of this subsection pertaining to the sharing of health-care resources described in such paragraph, and (B) such other matters as the Committee considers appropriate in order to promote such sharing of health-care resources.

"(c)(1) After considering the recommendations made under subsection (b)(4) of this section, the Administrator and the Secretary of Defense shall jointly establish guidelines to promote the sharing of health-care resources between the agencies. Guidelines established under their subsection shall provide for such sharing consistent with the health-care responsibilities of the Veterans' Administration under this title and with the health-care responsibilities of the Department of Defense under chapter 55 of title 10 and so as not to adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency.

"(2) Guidelines established under paragraph (1) of this subsection shall authorize the heads of individual medical facilities of the agencies to enter into health-care resources sharing agreements in accordance with subsection (d) of this section and shall include guidelines for such agreements.

"(d)(1) The head of each medical facility of either agency is authorized to enter into sharing agreements with the heads of medical facilities of the other agency in accordance with guidelines established under subsection (c) of this section. Under any such agreement, an individual who is a primary beneficiary of one agency may be provided health care at a facility of the other agency that is a party to the sharing agreement.

"(2) Each such agreement shall identify the health-care resources to be shared.

"(3) Each such agreement shall provide, and shall specify procedures designed to ensure, that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency (A) is on a referral basis from the facility of the other agency, and (B) does not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided to the primary beneficiaries of the providing agency.

"(4) Each such agreement shall provide that a providing agency shall be reimbursed for the cost of the health-care resources provided under the agreement and that the rate for such reimbursement shall be determined in accordance with the methodology agreed to pursuant to subsection (e) of this section.

"(5) Each proposal for an agreement under paragraph (1) of this subsection shall be submitted to the Chief Medical Director and the Assistant Secretary and shall be effective as an agreement in accordance with its terms (A) on the forty-sixth day after the receipt of such proposal by both such officials, unless earlier disapproved by either such official, or (B) if earlier approved by both such officials, on the date of such approval.

"(e) Reimbursement under any sharing agreement entered into under subsection (d) of this section shall be based upon a methodology that is agreed upon by the Chief Medical Director and the Assistant Secretary and that provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and needs and the actual costs to the providing agency's facility of the health-care resources provided. Any funds received through such a reimbursement shall be credited to funds that have been allotted to the facility that provided the care or services.

"(f) At the time the President's Budget is transmitted to Congress in any year pursuant to section 201(a) of the Budget and Accounting Act, 1921 (31, U.S.C. 11(a)), the Administrator and the Secretary of Defense shall submit a joint report to Congress on the implementation of this secton during the fiscal year that ended during the previous calendar year. Each such report shall include—

"(1) the guidelines prescribed under subsection (c) of this section (and any revision of such guidelines);

"(2) the assessment of further opportunities identified under clause (B) of subsection (b)(3) of this section for sharing of health-care resources between the agencies;

"(3) any recommendation made under subsection (b)(4) of this section during such fiscal year;

"(4) a review of the sharing agreements entered into under subsection (d) of this section and a summary of activities under such agreements during such fiscal year;

"(5) a summary of other planning and activities involving either agency in connection with promoting the coordination and sharing of Federal health-care resources during the preceding fiscal year; and

"(6) such recommendations for legislation as the Administrator and the Secretary consider appropriate to facilitate the sharing of health-care resources between the agencies.

"(g) For the purposes of this section:

"(1) The term 'beneficiary' means a person who is a primary beneficiary of the Veterans' Administration or of the Department of Defense.

"(2) The term 'direct health care' means health care provided to a beneficiary in a medical facility operated by the Veterans' Administration or the Department of Defense.

"(3) The term 'head of a medical facility' (A) with respect to a medical facility of the Veterans' Administration, means the director of the facility, and (B) with respect to a medical facility of the Department of Defense, means the medical or dental officer in charge or the contract surgeon in charge.

"(4) The term 'health-care resource' includes hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 601 of this title, any other health-care service, and any health-care support or administrative resource.

"(5) The term 'primary beneficiary' (A) with respect to the Veterans' Administration means a person who is eligible under this title (other than under section 611(b) or 613 or subsection (d) of this section) or any other provision of law for care or services in Veteran's Administration medical facilities, and (B) with respect to the Department of Defense, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10.

"(6) The term 'providing agency' means the Veterans' Administration, in the case of care or services furnished by a facility of the Veterans' Administration, and the Department of Defense, in the case of care or services furnished by a facility of the Department of Defense.".

(b)(1) The heading of such section is amended to read as follows:

"§ 5011. Sharing of Veterans' Administration and Department of Defense health-care resources".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 of such title is amended to read as follows:

"5011. Sharing of Veterans' Administration and Department of Defense health-care resources.".

(c) The Assistant Secretary of Defense for Health Affairs shall consult regularly with the Surgeons General of the Army, Navy, and Air Force in carrying out the duties and functions assigned to the Assistant Secretary in section 5011 of title 38, United States Code, as amended by subsection (a) of this section.

(d) The guidelines required to be established under subsection (c) of section 5011 of title 38, United States Code, as added by subsection (a) of this section, shall initially be established not later than 12 months after the date of the enactment of this Act.

Sec. 4. (a) Chapter 81 of title 38, United States Code, is amended by inserting after section 5011 the following new section:

"§ 5011A. Furnishing of health-care services to members of the Armed Forces during a war or national emergency

"(a)(1) During and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict, the Administrator may furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Administrator may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Veterans' Administration with the exception of veterans with service-connected disabilities.

"(2) For the purposes of this section, the terms 'hospital care', 'nursing home care', and 'medical services' have the meanings given such terms by sections 601(5), 101(28), and 601(6) of this title, respectively.

"(b)(1) During a period in which the Administrator is authorized to furnish care and services to members of the Armed Forces under subsection (a) of this section, the Administrator, to the extent authorized by the President and subject to the availability of appropriations or reimbursements under subsection (c) of this section, may enter into contracts with private facilities for the provision during such period by such facilities of hospital care and medical services described in paragraph (2) of this subsection.

"(2) Hospital care and medical services referred to in paragraph (1) of this subsection are—

"(A) hospital care and medical services authorized under this title for a veteran and necessary for the care or treatment of a condition for which the veteran is receiving medical services at a Veterans' Administration facility under subsections (f) and (g) of section 612 of this title, in a case in which they delay involved in furnishing such care or services at such Veterans' Administration facility or at any other Veterans' Administration facility reasonably accessible to the veteran would, in the judgment of the Chief Medical Director, be likely to result in a deterioration of such condition; and

"(B) hospital care for a veteran who—

"(i) is receiving hospital care under section 610 of this title; or

"(ii) is eligible for hospital care under such section and requires such care in a medical emergency that poses a serious threat to the life of health of the veteran;

if Veterans' Administration facilities are not capable of furnishing or continuing to furnish the care required because of the furnishing of care and services to members of the Armed Forces under subsection (a) of this section.

"(c)(1) The cost of any care of services provided by the Veterans' Administration under subsection (a) of this section shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense based on the cost of the care or services provided.

"(2) Amounts received under this subsection shall be credited to funds allotted to the Veterans' Administration facility that provided the care or services.

"(d)(1) Not later than six months after the date of the enactment of this section, the Administrator and the Secretary of Defense shall enter into an agreement to plan and establish procedures and guidelines for the implementation of this section. Not later than one year after the date of the enactment of this section, the Administrator and the Secretary shall complete plans for such implementation and shall submit such plans to the Committees on Veterans' Affairs and on Armed Services of the Senate and House of Representatives.

"(2) The Administrator and the Secretary of Defense shall jointly review such plans not less often than annually thereafter and shall report to such committees any modification in such plans within 30 days after the modification is agreed to.

"(e) The Administrator shall prescribe regulations to govern any exercise of the authority of the Administrator under subsections (a) and (b) of this section and of the Chief Medical Director under subsection (b)(2)(A) of this section.

"(f) Within 30 days after a declaration of a period of war or national emergency described in subsection (a) of this section (or as soon after the end of such 30-day period as is reasonably practicable), the Administrator shall submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report on the Administrator's allocation of facilities and personnel in order to provide priority hospital care, nursing home care, and medical services under this section to members of the Armed Forces. Thereafter, with respect to any fiscal year in which the authority in subsection (b) of this section to enter into contracts with private facilities has been used, the Administrator shall report within 90 days after the end of such fiscal year to those committees regarding the extent of, and the circumstances under which, such authority was used.".

(b) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 5011 the following new item:

"5011A. Furnishing of health-care services to members of the armed forces during a war or national emergency.".

SEC. 5. (a) Section 1786(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

"(3) Notwithstanding any other provision of law unless enacted in express limitation of this paragraph, funds in the Veterans' Administration readjustment benefits account shall be available for payments under paragraph (1) of this subsection for pursuit of a program of education exclusively by correspondence in which the veteran or spouse or surviving spouse enrolls after September 30, 1981.".

(b) The amendment made by subsection (a) of this section shall take effect as of October 1, 1981.

SEC. 6. The Veterans' Administration medical center located at 1481 West 10th Street, Indianapolis, Indiana, shall after the date of the enactment of this Act be known and designated as the "Richard L. Roudebush Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, document, map, record, or other paper of the United States shall after such date be deemed to be a reference to the Richard L. Roudebush Veterans' Administration Medical Center.

In lieu of the amendment of the House to the title of the bill, amend the title so as to read: "An Act to amend title 38, United States Code, to promote greater sharing of health-care resources between the Veterans' Administration and the Department of Defense and to direct the Secretary of Defense and the Administrator of Veterans' Affairs to plan for the provision of health care by the Veterans' Administration during periods of war or national emergency to members of the Armed Forces on active duty; and for other purposes.".

The PRESIDING OFFICER. The question is on agreeing to the amendment.

The amendment was agreed to.

The motion was agreed to.

Mr. SIMPSON. Madam President, this measure is before the Senate now as a privileged matter in lieu of the formal conference report.

SUMMARY

Madam President, I rise in strong support of S. 266, the proposed Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act. The provisions of S. 266, the Senate substitute amendment to the amendments of the House to S. 266, embodies a compromise reached after extensive negotiations between the two Veterans' Affairs Committees. S. 266 is designed to promote the coordination and sharing of health-care resources between the Veterans' Administration and the Department of Defense in order to reduce costs while inproving access to health care for beneficiaries of each agency. In addition, it would establish the Veterans' Administration health-care system as a primary reserve to the Department of Defense for treatment of combat casualties.

Madam President, I am most pleased that this final version of S. 266, which I believe to be a most equitable compromise, is ready to be voted on by the Senate. My esteemed colleague, Senator CHARLES H. PERCY, has been involved in the compromise process. the bill was originally referred to the Committee on Governmental Affairs and then sequentially referred to the Senate Committee on Veterans' Affairs. Senator PERCY has retained a very active interest in this legislation and this chairman has shared Senator PERCY's desire to improve the efficiency and effectiveness of Government programs in general. However, the committee, in negotiations with the House did not retain the provision, supported by Senator PERCY, which would have provided medical care to DOD dependents in VA facilities. Both the House Veterans' Affaris and Armed Services Committees were unwilling to accept provisions providing such authority. The veterans' service organizations and the VA's Chief Medical Director objected to this provision on the grounds that VA facilities are not presently equipped to handle either children or women in any significant numbers. They felt that to include such a provision would indicate congressional intent to modify VA hospitals to care for nonveterans.

The main portion of the bill addresses the VA and DOD equally in providing a mandate for the coordination and sharing of their health-care resources. An interagency committee, under the direction of the senior medical officials of the two agencies, would be responsible for reviewing policies, assessing further opportunities for sharing, providing guidance and engaging in related activities to foster effective interagency planning for resource utilization.

The remainder of the bill, Madam President, would amend title 38 to authorize specific agency actions in support of the coordination and sharing of health-care resources. A more lengthy and detailed discussion of provisions of the bill can be seen in the House/Senate joint explanatory statement which follows this statement.

Madam President, an amendment was offered by myself and the distinguished ranking minority member of the Veterans' Affairs Committee, Mr. CRANSTON when S. 266 first passed the Senate. This amendment, which was accepted by the House in our negotiations, would provide for the continuation of entitlement to GI bill benefits for correspondence training at the level agreed to in the Omnibus Reconciliation Act of 1981, Public Law 97-35. Both the House and Senate Veterans' Affairs Committees agreed to reduce from 70 to 55 percent the amount payable by the VA for correspondence training after September 30, 1981. This reduction was accomplished with legislative savings in mind, and we felt it was a fair and equitable response to both the needs of the veterans and the need for fiscal restraints. After this action the conferees on H.R. 4030, which was the HUD and Indpendent Agencies Appropriations Act for fiscal year 1982, eliminated all payments for correspondence training for those enrolled after September 1981. This issue is an important one which addresses the difference between programs funded as entitlements versus those funded through appropriations. Section 1661(a) of title 38 provides that a veteran "shall be entitled" to educational assistance under the GI bill. Therefore, this is not a discretionary program and falls within the area of VA entitlements which are not funded through annual appropriations. The restoration of this program through S. 266 provides an important distinction between entitlement and authorized programs. A September 30, 1981 general counsel's opinion states that correspondence courses are unquestionably an entitlement under title 38. However, the VA has suspended payments for correspondence courses pending a resolution of this issue. I believe that restoration of correspondence benefits at the reduced rate in this bill would resolve the matter and allow the VA to continue payments to those eligible veterans who continue to enroll in correspondence training.

Madam President, in conclusion I wish to extend my sincere thanks to the distinguished ranking minority member from California, Senator Cranston, for his tireless and invaluable efforts in the compromise process as well as each and every committee member who supported the compromise unanimously.

Additionally, I would like to recall the efforts of Edward Kelty, no longer with the committee, who worked long and hard on this measure, staff director and chief counsel, Tom Harvey, Julie Susman, Laurie Altemose, and our editorial director, Harold Carter. Thank you as well to members of Senator Cranston's very competent staff, Jonathan Steinberg, Edward Scott, Bill Brew, Ingrid Post, and Katie Burdick for their major contributions in this matter.

Madam President, I strongly support the compromise as an equitable and practical resolution on the differences between the original House and Senate versions of S. 266 and endorse its final passage by the Senate. Thank you, Madam President.

A House/Senate explanatory statement follows in lieu of the joint statement which would accompany a formal conference report. I ask unanimous consent to print it in the Record.

There being no objection, the statement was ordered to be printed in the Record, as follows:

Explanatory Statement of Senate Bill, House Amendment (H.R. 3502), and Compromise Agreement on S. 266, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act"

CONGRESSIONAL FINDINGS

Both the Senate bill, in a freestanding provision, and the House amendment, in an amendment to title 38 of the United States Code, would express Congressional findings relating to the sharing of health-care resources between the Verterans' Administration and the Department of Defense (hereinafter generally referred to as "the agencies").

The compromise agreement would express such findings, the specifics of which are discussed below, in a freestanding provision.

The Senate bill would include a finding that there are opportunities for greater sharing between the agencies and that increased sharing would be beneficial to veterans, members of the Armed Forces on active duty, and other health-care beneficiaries of the agencies. The House amendment would include a finding in this regard limited to veterans and members of the Armed Forces on active duty.

The compromise agreement follows the House amendment, but the reference to member of the Armed Forces is not restricted to those on active duty.

The Senate bill, but not the House amendment, would include findings that greater sharing between the agencies would result in reduced costs by minimizing duplication and underutilization of health-care resources, that there are not adequate incentives to encourage such sharing, and that such sharing may be achieved without a detrimental effect on each agency's primary beneficiaries.

The compromise agreement contains these findings.

The Sentate bill, but not the House amendment, would include further Congressional findings relating to the role of the VA health-care system as a backup to the health-care resources of the Department of Defense in the time of war or national emergency.

The compromise agreement contains these provisions.

SHARING OF VA AND ARMED FORCES FACILITIES

Both the Senate bill and the House amendment would amend present section 5011 of title 38, relating to sharing of VA and Armed Forces health-care facilities, to make the provisions of the present section a new subsection (a). The Senate bill would add "other resources" to the list of items that may be subject to mutual-use or exchange-of-use agreements and would delete the prohibition against any such agreement that would result in a permanent reduction of the number of VA hospital and domiciliary beds to levels below the number established or approved on June 22, 1944, plus the estimated number required to meet the load of current eligibles, and replace that prohibition with one precluding any such agreement that would result in a permanent reduction of VA beds below any minimum number prescribed by law.

The House amendment would delete the above-mentioned reference to the June 22, 1944, VA hospital and domiciliary bed levels in the current-law prohibition and substitute a reference to VA hospital, domiciliary, and nursing home bed levels established or approved under section 5010 of title 38.

The compromise agreement contains the amendments proposed in the Senate bill with technical amendments to refer to section 5010(a)(1) of title 38 and reflect the amendments made in that section by section 108 of Public Law 97-72.

ESTABLISHMENT OF VA/DOD COMMITTEE

Both the Senate bill, in a freestanding provision, and the House amendment, in an amendment to present section 5011 of title 38, would establish a Veterans' Administration/Department of Defense Committee to promote the sharing of health-care resources between the agencies. The Senate bill would have as members of the Committee the VA's Chief Medical Director, the Assistant Secretary of Defense for Health Affairs (referred to as "the Assistant Secretary"), or their respective designees, and other employees mutually designated. The House amendment would have as members the Chief Medical Director and the Assistant Secretary or their respective designees.

The compromise agreement contains a provision, in an amendment to present section 5011 of title 38 (adding a new subsection (b) (1) and (2)), to establish, for the purpose of promoting health-care resources sharing, a "Veterans' Administration/Department of Defense Health-Care Resources Sharing Committee" (hereinafter referred to as the "VA/DoD Committee") with the Chief Medical Director, Assistant Secretary, and such other officers and employees of their respective agencies as they each designate as members. The size of the Committee would be mutually determined by the Chief Medical Director and the Assistant Secretary. The Chief Medical Director would chair the Committee in fiscal years 1982 and 1983, the Assistant Secretary would chair it in fiscal year 1984, and thereafter the chairmanship would alternate between them each subsequent fiscal year. Administrative support services for the Committee would be required to be provided by the VA and DoD on an equitable basis.

DUTIES OF VA/DOD COMMITTEE

The Senate bill would require the VA/DoD Committee to take certain actions, on a continuing basis, in order to promote coordination of health-care services between the agencies and to provide guidance to the agencies in regard to sharing health-care resources. The House amendment would require the Committee to take certain actions, regularly, to maintain oversight of opportunities for sharing medical resources between the two agencies and to make recommendations to the heads of the agencies with respect to such sharing.

The compromise agreement contains a provision that would require the Committee to take certain actions (described below), on a continuing basis, in order to enable it to make recommendations to the Administrator or the Secretary of Defense or both for promoting sharing of health-care resources between the agencies. (The term "health-care resources" would be broadly defined, as described below under the heading "Definitions".)

The Senate bill would require the Committee to take the following actions:

Review existing policies and practices in regard to coordination and sharing of health-care resources between the agencies;

Identify and assess further opportunities for the coordination and sharing of health-care resources between the agencies that would not adversely affect the quality of, or the established priorities for, care provided by either agency;

Develop and recommend to the agency heads changes in existing policies and procedures to produce maximum feasible coordination and sharing of health-care resources between the agencies as authorized by title 38;

Monitor plans of the agencies to acquire additional health-care resources and review the potential impact of such proposals on opportunities for such coordination and sharing as would not adversely affect the quality of, or the established priorities for, care provided by either agency; and

develop, in consultation with other agencies as directed by the President, a plan for the effective utilization of VA resources as a backup to DoD during a period of war or national emergency.

The House amendment would require the Committee to take the following actions:

assess the opportunities for sharing of existing medical resources between the agencies;

keep each agency apprised of the other's plans for any additional medical facilities and for the acquisition of major new medical equipment with regard to the impact of such plans on opportunities for sharing;

review the existing direct health-care capabilities of the two agencies in order to identify opportunities for sharing that will not adversely affect the quality, or the established priority, of care provided by either agency; and

recommend to the Administrator and the Secretary of Defense policies and procedures designed to maximize the sharing of medical resources by the two agencies.

The compromise agreement (in new subsection (b)(3) of section 5011) would require the VA/DoD Committee—in order to enable the Committee to make recommendations to the Administrator or the Secretary of Defense, or both, with respect to changes in policies pertaining to the sharing of health-care resources between the agencies—to take the following actions:

review existing policies, procedures, and practices relating to the sharing of health-care resources between the agencies;

identify and assess further opportunities for the sharing of health-care resources between the agencies that would not, in the judgment of the VA/DoD Committee, adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency;

identify changes in policies, procedures, and practices that would, in the judgment of the VA/DoD Committee, promote such sharing of health-care resources between the agencies ("such sharing" refers to sharing that would not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency);

monitor the plans of the agencies for acquiring additional health-care resources in order to assess the potential impact of such plans on further opportunities for such sharing of health-care resources between the agencies; and

monitor the implementation of activities by the agencies designed to promote the sharing of health-care resources between the agencies.

The compromise agreement also contains a provision (new subsection (b)(4) of section 5011) requiring the VA/DoD Committee, within nine months of the date of enactment of this measure and thereafter as the Committee determines appropriate, to make recommendations to the Administrator of Veterans' Affairs or the Secretary of Defense or both with respect to changes in policies, procedures, and practices and other matters that would promote such sharing of health-care resources between the agencies as would not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency.

GUIDELINES FOR SHARING VA/DOD HEALTH-CARE RESOURCES

Both the Senate bill and the House amendment would require the Administrator and the Secretary of Defense jointly to establish guidelines for the sharing of health-care resources between the agencies. The Senate bill would require that the guidelines be established not later than nine months after the date of enactment; the House amendment, not later than one year after the date of enactment. The Senate bill would specify that the guidelines are for sharing to the maximum extent feasible consistent with the health-care responsibilities of the two agencies under titles 38 and 10, respectively, of the United States Code.

The compromise agreement (in new subsection (c)(1) of section 5011) would require the Administrator and the Secretary of Defense, after considering the recommendations of the VA/DoD Committee, jointly to establish guidelines to promote such sharing of health-care resources as would be consistent with the health-care responsibilities of the two agencies under title 38 and chapter 5 of title 10, respectively, and that would not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency. Section 3(d) of the bill would require the guidelines initially to be established within 12 months after the date of enactment.

The Senate bill would require that the guidelines include provisions for the following:

The director or commanding officer of each health-care facility under the jurisdiction of either of the two agencies shall, to the maximum extent feasible, appropriate, and consistent with the responsbilities of the agencies, enter into sharing agreements with the head of each health-care facility of the other agency in the same geographic area, under which agreements the eligible beneficiaries of one agency identified in the agreement may be provided health care at the facility of the other agency;

Each agreement shall explicity identify the health-care resources to be shared, the health care to be provided, and the beneficiaries to be treated;

Each agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not adversely affect the range of services, quality of care, or priority for services provided to that agency's primary beneficiaries;

Each agreement shall be submitted to the Chief Medical Director and the Assistant Secretary on the same day and shall become an interagency agreement on the forty-sixty day following receipt, unless earlier disapproved by either official or, if earlier approved by both officials, on the date of approval;

Each agreement shall provide for reimbursement to the providing agency based on a methodology, agreed upon by the Chief Medical Director and the Assistant Secretary, which provides appropriate flexibility to the heads of local facilities to take into account local conditions and needs and the actual costs to the facility that provided the care; and

The reimbursement shall be credited to the appropriations available to the facility which provided the care or services.

The House amendment would require that the guidelines include provision for the following:

The director of a VA health-care facility or the officer in charge of a DoD facility may enter into cooperative sharing agreements with health-care facilities of the other agency under which an individual entitled to direct health care in a facility of one agency may be provided care at the facility of the other agency;

each agreement shall explicitly define the health care to be provided, and services to be shared may include any medical resource that is agreed upon; and

each agreement shall ensure that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency shall be on a referral basis and shall not adversely affect the range of services, quality of care, or priority access for services provided to the agency's primary beneficiaries.

The House amendment would also require that whenever a beneficiary receives medical services from the agency of which the individual is not a primary beneficiary, that agency shall be reimbursed based upon a costing methodology that is agreed to by the Administrator and the Secretary and is based upon the cost of the services provided, and that the reimbursement shall be credited to the appropriation and to the facility that provided the services.

Both the Senate bill and the House amendment would define the terms "beneficiary" and "primary beneficiary" in a similar manner (the principal difference between the two bills being that the Senate definitions would include dependents). The definitions of these terms adopted in the compromise agreement are described below under the heading "Definitions".

The compromise agreement (in new subsection (c)(2) of section 5011) would require the guidelines to authorize the heads of individual medical facilities to enter into sharing agreements in accordance with provisions in new subsection (d) of section 5011, which provide as follows:

the head of each health-care facility of either agency is authorized to enter into sharing agreements with the heads of health-care facilities of the other agency under which primary beneficiaries of one agency may be provided care at a facility of the other agency that is a party to the agreement;

each agreement must identify the health-care resources to be shared;

each agreement must provide, and must specify procedures designed to ensure, that the availability of health care under sharing agreements to individuals who are not primary beneficiaries of an agency shall be on a referral basis and shall not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided by the facility of the providing agency to that agency's primary beneficiaries;

Each agreement must specify that the providing agency shall be reimbursed by the other agency at a rate to be determined pursuant to the provisions of new subsection (e) of section 5011, discussed below; and

Each proposal for an agreement shall be submitted to the Chief Medical Director and the Assistant Secretary, and each such proposal shall be effective as an agreement in accordance with its terms on the forty-sixth day after receipt by both officials, unless earlier disapproved by either official, or if earlier approved by both officials, on the date of such approval.

The Committees note that by not including in the compromise agreement the geographic limitation on sharing authority contained in the Senate bill ("in the same geographic area"), it is their intent that the head of a health-care facility of one agency should have maximum flexibility to enter into sharing agreements with heads of health-care facilities of the other agency and that, although the Committees anticipate that the vast preponderance of sharing agreements will be entered into by geographically proximate facilities, such a result will occur only because the access to care by the agencies' beneficiaries would be greatest in the case of such facilities. With further reference to the Committees' intent that the heads of health-care facilities have maximum flexibility when entering into sharing agreements, the Committees note that such agreements would not have to cover all of the beneficiaries of the health-care facility of one agency but rather could be limited in their coverage to specific categories of individuals (such as all beneficiaries in need of treatment for a heart disease) as agreed to by the heads of the health-care facilities entering into a sharing agreement.

With reference to the provision in the compromise agreement specifying that the availability of direct health care under sharing agreements shall not adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency, the Committees note that this provision would require that before a VA facility that acquires additional in-house medical or dental care capacity proceeds to share any of that capacity, that new capacity should be applied to the care of veterans who were being treated on a fee basis by virtue of the VA's prior lack of capacity to treat them (as provided for in section 601(4)(C) of title 38).

The Committees note that the House amendment, in making reference to beneficiaries who could receive care under a sharing agreement, referred to individuals "entitled" to health care in VA or DoD facilities. By using the term "eligible" for care in the compromise agreement, the Committees are expressing no view about which beneficiaries of either agency's health-care system may have legal entitlements to care or services, since resolution of that issue is not necessary to provide the authorization, set forth in the compromise agreement, for the two agencies to enter into sharing agreements.

The compromise agreement contains a further provision (new subsection (e) of section 5011) requiring the reimbursement under a sharing agreement be based on a methodology agreed upon by the Chief Medical Director and the Assistant Secretary that provides appropriate flexibility to the heads of local facilities to take into account local conditions and needs and the actual costs to the providing facility. Reimbursements would be required to be credited to funds that have been alloted to the facility that provided the care or services.

The Committees note that, in adopting this approach to reimbursement between the agencies emphasizing local flexibility and the actual costs to the providing facility of the care or services provided, it is their intention that the agencies be allowed to reimburse one another without reference to any standard rate or rates established by the Office of Management and Budget. The inflexible application of OMB standard rates has been cited as one barrier to greater interagency sharing under current law, and the Committees do not believe that it should be permitted to continue. In this regard, the Committees note the provision in the compromise agreement (new section 5011A(c)(1) of title 38 as propsed to be added by section 4(a) of the bill, discussed below) relating to reimbursement of VA by DoD for the care or services provided by the VA to active duty members of the Armed Forces in time of war or national emergency. That provision requires reimbursement "based on the cost of the care or services provided". As noted below, the Committees believe that it would not be inappropriate under that formulation for the agencies to rely on an OMB-determined standard rate because the rate of reimbursement in that context is not expected to be a significant factor in the making of arrangements for the VA to provide care for combat casualties.

REPORT ON SHARING OF VA/DOD HEALTH-CARE RESOURCES

Both the Senate bill and the House amendment would require the Administrator and the Secretary to submit an annual joint report to the Congress, at the time the President's Budget is transmitted to the Congress, on the agencies' activities in carrying out the provisions of the compromise agreement relating to the guidelines for sharing.

The compromise agreement contains a provision (new subsection (f) of section 5011), derived from the provisions of the Senate bill and the House amendment, requiring that the joint annual report include information with respect to:

the guidelines (and any revisions thereof) prescribed by the agencies pursuant to the compromise agreement provisions described above relating to those guidelines;

the assessment of opportunities for further sharing identified by the VA/DoD Committee pursuant to the compromise agreement provisions described above relating to that Committee;

the recommendations to the Administrator and the Secretary made by the VA/DoD Committee pursuant to those same compromise agreement provisions for changes in the policies, procedures, and practices of the agencies in order to promote sharing of health-care resources;

a review of sharing agreements entered into by the agencies pursuant to the guidelines and a summary of the activities of the agencies under those sharing agreements;

a summary of other planning and activities involving either agency (but not necessarily the other) in connection with promoting the coordination and sharing of Federal health-care resources during the fiscal year covered by the report as well as activities involving the two agencies but not pursuant to a sharing agreement entered into under section 5001; and recommendations for legislation that the Administrator and Secretary consider appropriate to facilitate the sharing of health-care resources between the agencies.

DEFINITIONS

Both the Senate bill and the House amendment would include definitions of terms used in the provisions relating to interagency sharing.

The compromise agreement (in new subsection (g) of section 5011) would define various terms used in such provisions as follows:

"Beneficiary"—a person who is a primary beneficiary (a term also defined, as described below) of the VA or DoD.

"Direct health care"—health care provided in a facility operated by the VA or DoD.

"Head of a medical facility"—(A) in the case of a facility under the jurisdiction of the VA, the director, and (B) in the case of a facility under the jurisdiction of DoD, the medical or dental officer in charge or the contract surgeon in charge.

"Health-care resource"—any health-care resource, including hospital care, medical services, and rehabilitative services as those terms are defined in paragraphs (5), (6), and (8), respectively, of present section 601 of title 38, any other health-care service, and any health-care support or administrative resource.

"Primary beneficiary"—(A) with respect to the VA, a person who is eligible, under the provisions of title 38 (other than present section 611(b) of title 38, relating to non-veterans' eligibility for care in emergencies, present section 613 of title 38, relating to eligibility for care for certain dependents and survivors of veterans, or the provision of law proposed to be added by the compromise agreement provision (new subsection (d) of section 5011) relating to interagency sharing agreements) or any other provision of law, for care or services in VA health-care facilities, and (B) with respect to DoD, a member or former member of the Armed Forces who is eligible for care under present section 1074 of title 10, relating to eligibility for medical and dental care for members and former members of the uniformed services. The difference between this definition and that of "beneficiary" (described above) is that "primary beneficiary" is defined with reference to each agency and is used in a provision (new subsection (d)(3) of section 5011) precluding a sharing agreement from having an adverse effect on either agency's services to its own beneficiaries.

"Providing agency"—either the VA or DoD, determined according to which agency's health-care facility actually furnishes the care or services in question.

Both the Senate bill and the House amendment would require the Assistant Secretary to consult regularly with the Surgeons General of the Army, Navy, and Air Force in carrying out the compromise agreement provisions described above.

The compromise agreement contains this provision in a freestanding provision in section 3(c) of the bill.

VA CONTINGENCY BACKUP TO DOD

Both the Senate bill and the House amendment would amend title 38 to authorize the Administrator, in time of war, or during a period of national emergency declared by the Congress or the President involving the use of the Armed Forces in armed conflict, to give a higher priority to the furnishing of care and services in VA facilities to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

The House amendment, but not the Senate bill, would require that, before this authority to provide priority VA care and services to active duty members of the Armed Forces could be exercised, the President would have to authorize such action. The Senate bill would require the Administrator to prescribe regulations prior to to exercising this new authority; the House amendment would require the Administrator to prescribe regulations only with reference to the exercise of the new authority to contract with private facilities (described below).

The compromise agreement contains a provision (subsection (a) (1) of new section 5011A) authorizing such priority care—without a requirement of advance Presidential authorization, but with a requirement that the Administrator prescribe regulations governing the exercise of this authority—and would extend the period during which this authority could be exercised to the period immediately following a period of war or national emergency so as to ensure that the VA could continue, after the cessation of hostilities, to care for the casualties from the period of armed conflict for such period of time as the national interest required.

The compromise agreement contains a provision (subsection (a) (2) of new section 5011A) specifying that the terms "hospital care", "nursing home care", and "medical servies" as used in new section 5011A have the meanings given such terms by section 601(5), 101(28), and 601(6) of title 38, respectively.

VA CONTRACT AUTHORITY IN WAR OR NATIONAL EMERGENCY

Both the Senate bill and the House amendment would provide authority for the Administrator to contract with private facilities for the provision of hospital care and medical services to certain groups of veterans, as discussed below, during a period of war or national emergency. The Senate bill would limit the exercise of this contracting authority to the extent authorized by the President; as described under the preceding heading, the House amendment would make the entire exercise of the contingency care authority by the VA dependent upon advance Presidential authorization. The Senate bill also would make the exercise of this authority subject to the availability of appropriations or of reimbursements to the VA from DoD for the costs of care rendered by the VA to active duty personnel pursuant to provisions of the compromise agreement described under the preceding heading; the House amendment makes the exercise subject just to the availability of appropriations.

The compromise agreement (subsection (b) of new section 5011A) would authorize the Administrator, to the extent authorized by the President and subject to the availability of appropriations or reimbursements, to enter into contracts with private facilities for the provision of hospital care and medical services to certain groups of veterans, as discussed below, during and immediately following a period of war or national emergency.

Under the Senate bill, the authority to contract with private facilities for hospital care or medical services for a veteran would be available to provide care and treatment for a condition for which a veteran is receiving medical services under title 38 provisions authorizing outpatient care (present subsections (f) and (g) of section 612) if the delay in furnishing the care at the VA facility concerned would, in the judgment of the Chief Medical Director pursuant to regulations prescribed by the Administrator, be likely to result in a significant deterioration of the veteran's condition. Under the House amendment, the contract authority for treatment of a veteran receiving VA medical services under the outpatient treatment provisions would be limited to hospital care and would be available in cases in which, in the Administrator's judgment, delay in providing care would likely result in a deterioration of the veteran's condition.

Under the compromise agreement (subsection (b) (1) and (2)(A) of new section 5011A), the Administrator would be authorized to enter into contracts with private facilities for such hospital care and medical services as are authorized under title 38 for a veteran and are necessary for the care or treatment of a condition for which a veteran is receiving medical services (outpatient treatment) at a VA facility under present subsection (f) or (g) of section 612 in a case in which the delay involved in furnishing the care at that facility or any other VA facility reasonably accessible to the veteran would, in the judgment of the Chief Medical Director, be likely to result in a deterioration of the condition. It is the Committees' intent that the VA should, in determining whether or not any other VA facility that could provide the needed care or services is reasonably accessible to the veteran, utilize the standard now applied by the agency for determining eligibility for fee-basis care because of geographic inaccessibility under present section 601(4)(C) of title 38.

The Senate bill would authorize the Administrator to contract with private facilities for hospital care for the treatment of a medical emergency which poses a serious threat to the life or health of a veteran eligible for care under chapter 17 of title 38 if the Chief Medical Director, pursuant to regulations prescribed by the Administrator, finds that the VA facility concerned is utilizing a substantial portion of its hospital care capability for the furnishing of priority care to members of the Armed Forces. The House amendment would provide similar contract authority for hospital care, as well as for medical services, in cases in which VA facilities are not capable of furnishing the care or services required because of furnishing care and services to members of the Armed Forces.

Under the compromise agreement (subsection (b)(1) and (2)(B) of new section 5011A), the Administrator would be authorized to enter into contracts with private facilities for hospital care for a veteran who is receiving VA hospital care or who is eligible for such care and requires hospital care in a medical emergency that poses a serious threat to the life or health of the veteran, if VA facilities are not capable of furnishing or continuing to furnish the care or services required because of furnishing care and services to members of the Armed Forces. This authority is broader than that included in either the Senate bill or the House amendment so as to ensure that if, in the case of war or national emergency, any veterans receiving VA hospital care for non-service-connected conditions or requiring hospital care on an emergency basis for such conditions are displaced by active-duty members of the Armed Forces pursuant to the new authority, the VA would have the authority to provide by contract for their continuing hospital care and, as generally authorized, necessary followup medical services.

Both the Senate bill and the House amendment would require that the cost of any care or services provided by the VA to members of the Armed Forces on active duty be reimbursed to the VA by DoD at rates as may be agreed upon by the Administrator and the Secretary of Defense based on the cost of the care and services provided, and that amounts received as reimbursements shall be credited to funds allotted to the VA facility that provided the care or services.

The compromise agreement contains this provision (subsection (c) of new section 5011A).

As noted above in the discussion of the compromise agreement provision relating to reimbursement between VA and DoD under sharing agreements, it does not seem inappropriate to the Committees for the reimbursement pursuant to this provision to be based on an OMB-determined standard rate since the rate of reimbursement in this context should not be a significant factor in the making of arrangements for the VA to provide care for combat casualties. Rather, the only significant purpose of the reimbursement formula in this context is to ensure that the VA is compensated fairly for the use of agency resources in support of DoD beneficiaries so that the costs of such care can be appropriately attributed and so that the VA will be able to continue to fulfill its primary mission of providing care to eligible veterans.

PLANNING FOR AND REPORTING ON CONTINGENCY BACKUP ROLE

The Senate bill, in a freestanding provision, and the House amendment, in a title 38 amendment, would require the Administrator and the Secretary of Defense, not later than 180 days after enactment, to enter into an agreement to pursue planning activities and establish procedures and guidelines for the VA to carry out the contingency backup function. The House amendment would further require that, not later than one year after the date of enactment, the Administrator and the Secretary complete the plans for the VA contingency backup function and submit them to the Committees on Veterans' Affairs and Armed Services of the Senate and the House of

Representatives. The House amendment would also require a joint review of these plans not less often than annually and a report to the same committees within 30 days of any modification to the plans.

The compromise agreement in title 38 provision (subsection (d) of new section 5011A), would require the Administrator and the Secretary, not later than 6 months after the date of enactment, to enter into an agreement to plan and establish procedures and guidelines for the implementation of the VA's contingency backup role. This compromise agreement provision would also require that, not later than one year after the date of enactment, the Administrator and Secretary complete plans for the implementation of the VA's contingency backup role and submit them to the Committees on Veterans' Affairs and Armed Services of both Houses and would require joint reviews of the plans not less often than annually and a report to these committees on any modification of the plans, to be submitted within 30 days of the modification.

Both the Senate bill and the House amendment would require the Administrator, at a specified point following a declaration of war or national emergency, to report to the Committees on Veterans' Affairs on the Administrator's allocation of facilities and personnel to provide care and services to members of the Armed Forces on active duty. The Senate bill would require that this report be submitted within 90 days after the declaration of war or national emergency or as soon thereafter as reasonably practicable; the House amendment would require that this report be submitted within 30 days after the President authorizes the VA to provide care to members of the Armed Forces on active duty. The Senate bill, but not the House amendment, would also require the Administrator, after submitting the first report, to report periodically thereafter to the committees regarding the extent to which, and the circumstances under which, the Administrator has utilized the authority to contract with private facilities as would be provided in conjunction with the VA's assuming a contingency backup function.

The compromise agreement (in subsection (f) of new section 5011A) would require the Administrator to submit to the Committees on Veterans' Affairs, within 30 days after the declaration of a period of war or national emergency or as soon thereafter as reasonably practicable, a report on the allocation of facilities and personnel in order to provide priority care and services to members of the Armed Forces on active duty. The compromise agreement would also require that, not later than 90 days after the end of any fiscal year in which the authority to contract with private facilities to provide care and services to certain veterans during a period of war or national emergency has been used, the Administrator report to the Veterans' Affairs Committee regarding the extent of, and the circumstances surrounding, the use of this authority during that fiscal year.

CORRESPONDENCE TRAINING UNDER THE GI BILL

The Senate bill, but not the House amendment, would amend section 1768 of title 38, relating to VA educational benefits for correspondence course training, to provide for the continued payment of GI Bill benefits for correspondence course training.

The compromise agreement contains this provision with technical amendments designed to ensure that funds are available and payable in fiscal year 1982 for correspondence training benefits.

The Committees note that in a January 4, 1982, memorandum prepared in the VA General Counsel's office, the view was expressed that the Senate provision would not be effective in achieving its intended objective—ensuring that fiscal year 1982 Readjustment Benefits account funds, notwithstanding any provision of law limiting the availability of such funds, are available for correspondence benefits in accordance with the provisions of section 1786 of title 38 as amended by the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). In light of that memorandum, technical changes have been made in this provision by the compromise agreement in order to make certain that the measure does achieve that objective.

VA MEDICAL CENTER INDIANAPOLIS NAMING

The Senate bill, but not the House amendment, would designate the VA Medical Center in Indianapolis, Indiana, as the "Richard L. Roudebush Veterans' Medical Center".

The compromise agreement contains this provision with a technical amendment to designate the center as the "Richard L. Roudebush Veterans' Administration Medical Center".

Mr. PERCY. Madam President, if this Congress is going to successfully trim the size of the Federal budget without jeopardizing vital services, we are going to have to scrutinize every Federal program to make sure it is being run with the utmost efficiency. This legislation, the Federal Interagency Medical Resources Sharing and Coordination Act, will promote such efficiency in the delivery of billions of dollars worth of medical care to Federal beneficiaries. It is not very often that we can pass legislation which will save millions of tax dollars while actually improving the quality of services provided Federal beneficiaries—yet that is precisely what S. 266 will do. I would like to express my deep appreciation to the distinguished chairman of the Senate Veterans' Affairs Committee, Senator CRANSTON, and the chairman of the House Veterans' Affairs Committee, Congressman MONTGOMERY, for their outstanding leadership on this issue.

In recent years, increasing concern has been expressed in the Congress over the spiraling costs of medical care in the Nation. As in the private sector, Federal agencies' costs to provide health care directly to beneficiaries have continued to rise, and substantial efforts have been made to find ways of holding down these costs without adversely affecting the quality of care.

Two years ago, I introduced the first legislation addressing the costly lack of sharing and coordination among the Veterans' Administration's and Defense Department's 308 hospitals. The introduction of this legislation followed a lengthy investigation by the General Accounting Office and the Governmental Affairs Committee. I am pleased to be the sponsor of S. 266 now before the Senate.

Examples of waste and inefficiency in the Federal Government's hospitals are plentiful. For instance:

In North Chicago, the VA and Navy operate hospitals less than a mile from each other. While the Navy's modern facility sits more than three-quarters empty because of a lack of doctors, forcing them to spend $3 million on private sector care, the VA nearby plans to spend $67 million in coming years on its crumbling 1905 era buildings. The VA enjoys a relative abundance of doctors. Current laws, regulations, and other problems have held up attempts to coordinate resources among the two Federal facilities.

For lack of a VA-Army agreement to share Boston VA orthopedic services, the Army flies dozens of patients from Boston to Walter Reed Hospital in Washington on its very expensive air evacuation system when more convenient and less costly treatment could be provided by the VA.

The purposes of this legislation are simple: To clear away the legal and administrative barriers to sharing, to create incentives at the local level, and to encourage the agencies to begin assessing money-saving opportunities for sharing and implement them expeditiously. The legislation also provides specific safeguards to prohibit sharing where it would adversely affect the quality of health care to Federal beneficiaries. Reaction to the bill has been nearly unanimous: This legislation is needed.

In moving this legislation through the House and Senate, several issues have been readied in which compromises have been worked out to the satisfaction of all sides. I am very pleased with the bipartisan support for the bill. There was one issue—whether military dependents should be allowed to be treated in VA hospitals under certain conditions—that we were unable to agree on. The final version of the bill would prohibit these patients from being treated under any conditions. I feel this is a mistake. Military dependents are now being treated in VA hospitals in many areas of the country on a space available, referral basis. While some have raised fears that these dependents would take beds needed by veterans, this simply would not be the case. There is absolutely no reason why a military dependent should not be able to have a CAT-scan or blood test—on an outpatient basis—at a VA hospital. VA doctors have said that such sharing could be continued without any adverse impact on the primary beneficaries of the VA. I will ask the GAO to re-examine this issue over the next year as we implement the provisions of S. 266. Should this prohibition prove unworkable, I will move to amend S. 266.

We have a unique opportunity with this bill to save hundreds of millions of tax dollars while enhancing Federal direct health care. In view of the difficult decisions this Congress faces in trying to cut Federal spending, I urge that we pass this bill and others that can save tax dollars without creating hardships for Federal beneficiaries.

Before concluding my statement, I would like to extend my thanks to Mr. David Baine and his staff at the General Accounting Office for their outstanding work in this area. I also would like to thank the members and staff of the Federal Health Resources Sharing Committee, especially Mr. Steven Arnt, for their contributions to this legislation.

Mr. CRANSTON. Madam President, as the ranking minority member of the Committee on Veterans' Affairs, I am very pleased to join with the committee chairman, my good friend from Wyoming (Mr. SIMPSON), in offering and urging the Senate to support the pending substitute amendment to the House amendment to S. 266, this amendment being a compromise agreed to between the two Veterans' Affairs Committees, the distinguished Senator from Illinois (Mr. PERCY) on behalf of the Senate Governmental Affairs Committee, and the House Armed Services Committee, after extensive discussion and negotiations. This measure, which addresses the appropriate relationship between the health-care resources of the Veterans' Administration and the Department of Defense both in peacetime and in time of war or national emergency involving armed conflict, is an important measure and deserves our strong support.

Madam President, this legislation was first passed by the Senate on October 22, 1981, at which point I spoke at some length regarding the background of the legislation, focusing most specifically on the efforts of the Committee on Veterans' Affairs to meld together aspects of S. 266 as originally introducted on January 27, 1980, by Senator PERCY and an amendment—amendment No. 62 to S. 636—that I offered on June 9, 1981. I refer my colleagues and others with an interest in this background to my remarks during that debate which began on page S12252 of the RECORD for October 27, 1981. Following Senate action, the House took up H.R. 3502, legislation dealing with the same matters, substituted its provisions into S. 266, and returned S. 266, as so amended, to the Senate. As I noted a moment ago, the legislation as it is now before the Senate represents a compromise agreement on the versions as passed by the two Houses.

Madam President, as with all compromises, the measure before the Senate today—which I will refer to as the compromise agreement—does not contain all of the provisions of either of the versions passed by the two Houses, nor does it reflect in every detail the result I would like to have achieved. Nevertheless, I believe that it does represent an equitable resolution of the differences between the two Houses and very substantially vindicates the basic position of the Senate. I am convinced it is a good bill and, in many individual respects and in general, a superior measure to what was passed in either House.

Madam President, the provisions of the compromise agreement are fully described in the "Explanatory Statement" that the chairman of the committee (Mr. SIMPSON) has inserted in the RECORD as part of his remarks and which will be inserted in identical form by the Chairman of the House Veterans' Affairs Committee (Mr. MONTGOMERY) when this measure is taken up in the other body in the next few days. I will, therefore, limit my remarks at this point to a brief discussion of some elements of the compromise agreement.

SHARING

Madam President, throughout committee consideration of this measure, I have been very supportive of the need for greater emphasis on the sharing of health-care resources between the VA and DOD. At the same time, however, I have been insistent that such sharing must not be permitted to have a detrimental impact on the ability of either of the two agencies to continue to provide quality health care to their respective beneficiaries under current law. I am very satisfied that this point of view has been recognized and is reflected in the provisions of the compromise agreement which relate to peacetime sharing. On this point, new subsection (d)(3) of section 5011 of title 38, United States Code, which would be added by section 3(a)(3) of the compromise agreement, provides, in relevant part, that each sharing agreement entered into by heads of health-care facilities of the two agencies—

> shall provide, and shall specify procedures designed to ensure, that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency . . . does not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided to the primary beneficiaries of the providing agency.

Madam President, I believe that this provision strikes the appropriate balance. This legislation is designed to promote sharing of health-care resources between the two agencies in a way that should yield improved access to health care for the beneficiaries of the two agencies while resulting in economies in the operation of the two health-care systems through more efficient utilization of their resources. At the same time, the compromise agreement reaffirms the continued importance of the VA's health-care system in providing timely, quality health care to beneficiaries eligible for care under the VA's basic health-care legislative authorities in title 38, United States Code, and other applicable law, such as section 2 of Public Law 95-126 regarding VA health care for certain veterans.

Madam President, the compromise agreement provides for the establishment of an interagency committee, the Veterans' Administration/Department of Defense Health-Care Resources Sharing Committee, which will have the VA's Chief Medical Director and the Assistant Secretary of Defense for Health Affairs as its principal members. This VA/DOD Committee will be responsible for developing information relating to the sharing of health-care resources between the two agencies and for promoting such sharing. Under provisions in the compromise agreement, the VA/DOD Committee will make recommendations to the administrator of Veterans' Affairs or the Secretary of Defense or both—initially, within 9 months of the date of enactment of the legislation and thereafter as appropriate—regarding steps that could be taken to promote sharing. After reviewing the initial recommendations, the Administrator and Secretary—within 12 months of the date of enactment—will jointly establish guidelines to promote sharing. Once the joint guidelines are issued, decisions regarding actual sharing, although subject to central guidance, will take place at the local level. This approach places the emphasis on sharing at the local, operational level where appropriate determinations regarding capacity to enter into sharing agreements can be made. This stress on local initiation and flexibility is one of the most important features of this portion of the bill.

Madam President, when this measure was before the Senate last October, I duscussed two issues relating to peacetime sharing that were of particular concern to the Senator from Illinois (Mr. **Percy**)—namely, the treatment of dependents under sharing agreements and insuring local autonomy in developing reimbursement rates in conjunction with sharing agreements—and the Veterans' Affairs Committee's action on these issues in the bill as reported out of our committee.

During the development of the compromise agreement, it was not possible to prevail on the issue of treating dependents, although the emphasis on local autonomy was retained in the agreement. I know that Senator **Percy**—as do Senator **Simpson** and I—would prefer that the result as to dependents would be as passed by the Senate but the opposition to that result from our colleagues in the House ws very substantial. I wish to thank the Senator from Illinois (Mr. **Percy**) for his understanding and cooperation in yielding on this point so that the compromise agreement, which we all agree addresses very important issues, could move forward today.

CARE FOR CASUALTIES OF ARMED CONFLICT

Madam President, in addition to providing a renewed emphasis on the sharing of health-care resources between the VA and DOD, the pending measure contains amendments to title 38 relating to the appropriate relationship of the health-care resources of the two agencies in time of war or national emergency involving the use of our Armed Forces in armed conflict when DOD facilities are unable to meet the increased demands resulting from combat casualties.

I consider the need to deal with that situation a very important matter and have urged that it be addressed in the context of the overall VA/DOD health-care resources relationship. I have long believed and stated that the VA should be the principal backup to the health-care resources of the Department of Defense in time of war or national emergency.

It has been very clear for a number of years that, in the event of major armed conflict, the Department of Defense would be unable to cope with more than a fraction of the anticipated casualties from such a conflict, and it is logical that the firstline backup to DOD in such a situation would be the VA health-care system. It is a large, comprehensive, nationwide system, and there is a natural linkage between the VA and DOD systems in that many beneficiaries of the DOD system become the beneficiaries of the VA at some point, a result that frequently occurs after a member of the Armed Forces is disabled in service and is then medically discharged.

Madam President, the compromise agreement would provide a basis for the VA to fulfill this contingency role by expressly authorizing the agency, during and immediately after a period of war or national emergency that involves the use of our Armed Forces in armed conflict, to provide hospital care, nursing home care, and medical services to members of the Armed Forces on a higher priority basis than to any other group of individuals other than veterans with service-connected conditions and by requiring the VA and DOD to plan for the VA to carry out this contingency role.

The specification of guidance for implementation of this new mission for the VA—which was established by section 108 of Public Law 97-72, a measure enacted last year that would require the VA to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency—should remove any impediment to the VA's working closely with DOD to develop contingency plans and, in the tragic event that the agency's health-care resources are ever needed to support the DOD in time of war or national emergency, the mechanism should be in place to carry out such a supportive role.

Madam President, in conjunction with this new authority, the pending measure would also provide very specific and carefully drawn authority for the Administrator, in situations in which the VA is treating Armed Forces personnel under the new authority and with the approval of the President, to contract with private health-care facilities to provide health care under certain circumstances to specified categories of veterans. I believe that this is an important adjunct to the new contingency authority and demonstrates that, even in situations in which the agency is treating wartime casualties, it has continuing veteran-care obligations.

CORRESPONDENCE TRAINING

I am very grateful to my colleagues in the House of Representatives for agreeing to include in this measure the Senate provision that I proposed to restore the availability of GI bill payments to Vietnam-era veterans for correspondence training in the current fiscal year. I feel very strongly that it is both unfair and contrary to the purposes of the GI bill to terminate the opportunity for these veterans to use their GI bill benefits for this type of training. For certain Vietnam-era veterans—particularly those whose current employment situation or other circumstances pose scheduling conflicts with classroom attendance, those with disabilities that render regular classroom attendance infeasible, and those residing in areas where other forms of education or training are not available—correspondence courses represent the only practical alternative for using the GI bill for the training they have chosen to pursue.

Moreover, I believe that the modifications that the Congress made in this program in 1980 and 1981 (Public Laws 96-466 and 97-35), increasing from 10 percent to 30 percent and then to 45 percent the share of the cost of the courses that the veteran must pay, are sufficient to eliminate whatever abuses may have been present in this program that motivated the administration to recommend its termination. Thus, I am gratified that we have been able to sustain the Senate provision in S. 266 on this issue, with certain clarifying modifications, as noted in the above-referenced explanatory statement, in order to carry out more explicitly the purpose of the Senate provision.

Madam President, in anticipation of the enactment of this provision, which has an effective date retroactive to October 1, 1981, I urge the VA promptly to initiate the remedial and outreach efforts necessary to ensure—in light of the VA's earlier action, based on what I believe to have been an incorrect interpretation of Public Law 97-101, the HUD-Indepdendent Agencies Appropriations Act, 1982, terminating the payment of correspondence training benefits for new enrollments after September 30, 1981—that all those who previously applied for these benefits this fiscal year and those who may wish to do so will be able to receive the benefits with respect to which this measure provides for clarification as to entitlement and availability of payment.

CONCLUSION

Madam President, as I noted earlier, I believe the compromise agreement represents a fair resolution of the differences between the two Houses. It gives full emphasis to peacetime sharing between the agencies while recognizing and respecting the separate missions and statutory authorities of the two agencies' health-care missions. Through the contingency authority provisions, it provides appropriate recognition of the fact that the relationship between the health-care resources of the two agencies should not be limited to peacetime efforts to reduce costs and eliminate duplication of effort but also must recognize the VA 's vital role as the first backup to the DOD in time of armed conflict.

Including both the sharing and contingency provisions in the same measure recognizes that, although there may be a certain tension between the two facets of the relationship of VA and DOD health-care resources in terms of the capacities each agency maintains, they must be considered together and any efforts to reduce the capability or capacity of either agency must be undertaken with an awareness of the need to maintain the health-care resources of the two agencies to care for battle casualties in the event of armed conflict.

Madam President, I want to express my appreciation to my good friend from Wyoming (Mr. SIMPSON) for his cooperative spirit as we have worked to develop the compromise agreement as it is before the Senate today. I also want to note the fine efforts of the Senator from Illinois (Mr. PERCY) on the issue of the peacetime sharing of VA and DOD health-care resources. His great interest in and persistence on this issue have been instrumental in bringing this legislation to its culmination and he is to be congratulated. I also want to express my appreciation to my good friends on the House Veterans' Affairs Committee, the chairman (Mr. MONTGOMERY) and the ranking minority member (Mr. HAMMERSCHMIDT) for their fine work in developing this measure. It has been, as always, a pleasure to work with them.

Madam President, I also express my appreciation for their fine work on this bill to the staff members of the House Veterans' Affairs Committee, Mack Fleming, Rufus Wilson, Ralph Casteel, and Jack McDonell; to Bob Cover, assistant counsel, House Legislative Counsel's Office; and to members of our committee staff, Tom Harvey and Julie Susman on the majority staff, and Bill Brew, Ed Scott, Jon Steinberg, Babette Polzer, Katy Burdick, Ingrid Post, and Charlotte Hughes on the minority staff.

Madam President, the compromise agreement now before the Senate is a most worthy measure, and I urge my colleagues to support it.

APPENDIX I

PUBLIC LAW 97-174—MAY 4, 1982

VETERANS' ADMINISTRATION AND DEPARTMENT OF DEFENSE HEALTH RESOURCES SHARING AND EMERGENCY OPERATIONS ACT

Public Law 97-174
97th Congress

An Act

May 4, 1982
[S. 266]

To amend title 38, United States Code, to promote greater sharing of health-care resources between the Veterans' Administration and the Department of Defense and to direct the Secretary of Defense and the Administrator of Veterans' Affairs to plan for the provision of health care by the Veterans' Administration during periods of war or national emergency to members of the Armed Forces on active duty; and for other purposes.

Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.
38 USC 101 note.
38 USC 5011 note.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act".

SEC. 2. (a) The Congress makes the following findings:

(1) There are opportunities for greater sharing of the health-care resources of the Veterans' Administration and the Department of Defense which would, if achieved, be beneficial to both veterans and members of the Armed Forces and could result in reduced costs to the Government by minimizing duplication and underuse of health-care resources.

(2) Present incentives to encourage such sharing of health-care resources are inadequate.

(3) Such sharing of health-care resources can be achieved without a detrimental effect on the primary health-care beneficiaries of the Veterans' Administration and the Department of Defense.

38 USC 5011A note.

(b) The Congress makes the following further findings:

(1) During and immediately after a period of war or national emergency involving the use of the Armed Forces of the United States in armed conflict, the Department of Defense might not have adequate health-care resources to care for military personnel wounded in combat and other active-duty military personnel.

(2) The Veterans' Administration has an extensive, comprehensive health-care system that could be used to assist the Department of Defense in caring for such personnel in such a situation.

SEC. 3. (a) Section 5011 of title 38, United States Code, is amended—

(1) by inserting "(a)" before "The Administrator" the first place it appears;

(2) by striking out "and material" and all that follows through "this title," and inserting in lieu thereof "material, and other resources as may be needed to operate such facilities properly, except that the Administrator may not enter into an agreement that would result (1) in a permanent reduction in the total number of authorized Veterans' Administration hospital beds and nursing home beds to a level below the minimum number of such beds required by section 5010(a)(1) of this title to be authorized, or (2) in a permanent reduction in the total number of such beds operated and maintained to a level

38 USC 5010.

below the minimum number of such beds required by such section to be operated and maintained"; and

(3) by adding at the end the following new subsections:

"(b)(1) In order to promote the sharing of health-care resources between the Veterans' Administration and the Department of Defense (hereinafter in this section referred to as the 'agencies'), there is established an interagency committee to be known as the Veterans' Administration/Department of Defense Health-Care Resources Sharing Committee (hereinafter in this subsection referred to as the 'Committee').

Veterans' Administration/ Department of Defense Health-Care Resources Sharing Committee. Establishment.

"(2) The Committee shall be composed of—

"(A) the Chief Medical Director and such other officers and employees of the Veterans' Administration as the Chief Medical Director may designate; and

"(B) the Assistant Secretary of Defense for Health Affairs (hereinafter in this section referred to as the 'Assistant Secretary') and such other officers and employees of the Department of Defense as the Assistant Secretary may designate,

except that the size of the Committee shall be mutually determined by the Chief Medical Director and the Assistant Secretary. During fiscal years 1982 and 1983, the Chief Medical Director shall be the chairman of the Committee. During fiscal year 1984, the Assistant Secretary shall be the chairman of the Committee. Thereafter, the chairmanship of the Committee shall alternate each fiscal year between the Chief Medical Director and the Assistant Secretary. The agencies shall provide administrative support services for the Committee at a level sufficient for the efficient operation of the Committee and shall share the responsibility for the provision of such services on an equitable basis.

Duties.

"(3) In order to enable the Committee to make recommendations under paragraph (4) of this subsection, the Committee shall on a continuing basis—

"(A) review existing policies, procedures, and practices relating to the sharing of health-care resources between the agencies;

"(B) identify and assess further opportunities for the sharing of health-care resources between the agencies that would not, in the judgment of the Committee, adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency;

"(C) identify changes in policies, procedures, and practices that would, in the judgment of the Committee, promote such sharing of health-care resources between the agencies;

"(D) monitor plans of the agencies for the acquisition of additional health-care resources, including the location of new facilities and the acquisition of major equipment, in order to assess the potential impact of such plans on further opportunities for such sharing of health-care resources; and

"(E) monitor the implementation of activities designed to promote the sharing of health-care resources between the agencies.

Recommendations to VA Administrator or DOD Secretary.

"(4) Within nine months of the date of the enactment of this subsection and at such times thereafter as the Committee considers appropriate, the Committee shall make recommendations to the Administrator or the Secretary of Defense, or both, with respect to (A) changes in policies, procedures, and practices that the Committee has identified under paragraph (3)(C) of this subsection pertaining to the sharing of health-care resources described in such paragraph, and (B) such other matters as the Committee considers appropriate in order to promote such sharing of health-care resources.

Health-care resources sharing guidelines.

"(c)(1) After considering the recommendations made under subsection (b)(4) of this section, the Administrator and the Secretary of Defense shall jointly establish guidelines to promote the sharing of health-care resources between the agencies. Guidelines established under this subsection shall provide for such sharing consistent with the health-care responsibilities of the Veterans' Administration under this title and with the health-care responsibilities of the Department of Defense under chapter 55 of title 10 and so as not to adversely affect the range of services, the quality of care, or the established priorities for care provided by either agency.

10 USC 1071 *et seq.*

"(2) Guidelines established under paragraph (1) of this subsection shall authorize the heads of individual medical facilities of the agencies to enter into health-care resources sharing agreements in accordance with subsection (d) of this section and shall include guidelines for such agreements.

Sharing agreements.

"(d)(1) The head of each medical facility of either agency is authorized to enter into sharing agreements with the heads of medical facilities of the other agency in accordance with guidelines established under subsection (c) of this section. Under any such agreement, an individual who is a primary beneficiary of one agency may be provided health care at a facility of the other agency that is a party to the sharing agreement.

"(2) Each such agreement shall identify the health-care resources to be shared.

"(3) Each such agreement shall provide, and shall specify procedures designed to ensure, that the availability of direct health care to individuals who are not primary beneficiaries of the providing agency (A) is on a referral basis from the facility of the other agency, and (B) does not (as determined by the head of the facility of the providing agency) adversely affect the range of services, the quality of care, or the established priorities for care provided to the primary beneficiaries of the providing agency.

Reimbursement.

"(4) Each such agreement shall provide that a providing agency shall be reimbursed for the cost of the health-care resources provided under the agreement and that the rate for such reimbursement shall be determined in accordance with the methodology agreed to pursuant to subsection (e) of this section.

Agreement proposals, submittal.

"(5) Each proposal for an agreement under paragraph (1) of this subsection shall be submitted to the Chief Medical Director and the Assistant Secretary and shall be effective as an agreement in accordance with its terms (A) on the forty-sixth day after the receipt of such proposal by both such officials, unless earlier disapproved by either such official, or (B) if earlier approved by both such officials, on the date of such approval.

Reimbursement methodology provisions.

"(e) Reimbursement under any sharing agreement entered into under subsection (d) of this section shall be based upon a methodology that is agreed upon by the Chief Medical Director and the Assistant Secretary and that provides appropriate flexibility to the heads of the facilities concerned to take into account local conditions and needs and the actual costs to the providing agency's facility of the health-care resources provided. Any funds received through such a reimbursement shall be credited to funds that have been allotted to the facility that provided the care or services.

Report to Congress.

"(f) At the time the President's Budget is transmitted to Congress in any year pursuant to section 201(a) of the Budget and Accounting Act, 1921 (31 U.S.C. 11(a)), the Administrator and the Secretary of Defense shall submit a joint report to Congress on the implementation of this section during the fiscal year that ended during the previous calendar year. Each such report shall include—

"(1) the guidelines prescribed under subsection (c) of this section (and any revision of such guidelines);

"(2) the assessment of further opportunities identified under clause (B) of subsection (b)(3) of this section for sharing of health-care resources between the agencies;

"(3) any recommendation made under subsection (b)(4) of this section during such fiscal year;

"(4) a review of the sharing agreements entered into under subsection (d) of this section and a summary of activities under such agreements during such fiscal year;

"(5) a summary of other planning and activities involving either agency in connection with promoting the coordination and sharing of Federal health-care resources during the preceding fiscal year; and

"(6) such recommendations for legislation as the Administrator and the Secretary consider appropriate to facilitate the sharing of health-care resources between the agencies.

"(g) For the purposes of this section: Definitions.

"(1) The term 'beneficiary' means a person who is a primary beneficiary of the Veterans' Administration or of the Department of Defense.

"(2) The term 'direct health care' means health care provided to a beneficiary in a medical facility operated by the Veterans' Administration or the Department of Defense.

"(3) The term 'head of a medical facility' (A) with respect to a medical facility of the Veterans' Administration, means the director of the facility, and (B) with respect to a medical facility of the Department of Defense, means the medical or dental officer in charge or the contract surgeon in charge.

"(4) The term 'health-care resource' includes hospital care, medical services, and rehabilitative services, as those terms are defined in paragraphs (5), (6), and (8), respectively, of section 601 of this title, any other health-care service, and any health-care support or administrative resource.

"(5) The term 'primary beneficiary' (A) with respect to the Veterans' Administration means a person who is eligible under this title (other than under section 611(b) or 613 or subsection (d) of this section) or any other provision of law for care or services in Veterans' Administration medical facilities, and (B) with respect to the Department of Defense, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10.

38 USC 611, 613.

"(6) The term 'providing agency' means the Veterans' Administration, in the case of care or services furnished by a facility of the Veterans' Administration, and the Department of Defense, in the case of care or services furnished by a facility of the Department of Defense.".

(b)(1) The heading of such section is amended to read as follows: 38 USC 5011.

"§ 5011. Sharing of Veterans' Administration and Department of Defense health-care resources".

(2) The item relating to such section in the table of sections at the beginning of chapter 81 of such title is amended to read as follows:

"5011. Sharing of Veterans' Administration and Department of Defense health-care resources.".

38 USC 5011 note.

(c) The Assistant Secretary of Defense for Health Affairs shall consult regularly with the Surgeons General of the Army, Navy, and Air Force in carrying out the duties and functions assigned to the Assistant Secretary in section 5011 of title 38, United States Code, as amended by subsection (a) of this section.

38 USC 5011 note.

(d) The guidelines required to be established under subsection (c) of section 5011 of title 38, United States Code, as added by subsection (a) of this section, shall initially be established not later than twelve months after the date of the enactment of this Act.

SEC. 4. (a) Chapter 81 of title 38, United States Code, is amended by inserting after section 5011 the following new section:

38 USC 5011A.

"§ 5011A. Furnishing of health-care services to members of the Armed Forces during a war or national emergency

"(a)(1) During and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict, the Administrator may furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Administrator may give a higher priority to the furnishing of care and services under this section than to the furnishing of care and services to any other group of persons eligible for care and services in medical facilities of the Veterans' Administration with the exception of veterans with service-connected disabilities.

Definitions.

38 USC 601, 101

"(2) For the purposes of this section, the terms 'hospital care', 'nursing home care', and 'medical services' have the meanings given such terms by sections 601(5), 101(28), and 601(6) of this title, respectively.

Contracts with private facilities.

"(b)(1) During a period in which the Administrator is authorized to furnish care and services to members of the Armed Forces under subsection (a) of this section, the Administrator, to the extent authorized by the President and subject to the availability of appropriations or reimbursements under subsection (c) of this section, may enter into contracts with private facilities for the provision during such period by such facilities of hospital care and medical services described in paragraph (2) of this subsection.

"(2) Hospital care and medical services referred to in paragraph (1) of this subsection are—

38 USC 612.

"(A) hospital care and medical services authorized under this title for a veteran and necessary for the care or treatment of a condition for which the veteran is receiving medical services at a Veterans' Administration facility under subsection (f) or (g) of section 612 of this title, in a case in which the delay involved in furnishing such care or services at such Veterans' Administration facility or at any other Veterans' Administration facility reasonably accessible to the veteran would, in the judgment of the Chief Medical Director, be likely to result in a deterioration of such condition; and

"(B) hospital care for a veteran who—

"(i) is receiving hospital care under section 610 of this title; or

38 USC 610.

"(ii) is eligible for hospital care under such section and requires such care in a medical emergency that poses a serious threat to the life or health of the veteran;

if Veterans' Administration facilities are not capable of furnishing or continuing to furnish the care required because of the furnishing of care and services to members of the Armed Forces under subsection (a) of this section.

Care or service costs, reimbursement.

"(c)(1) The cost of any care or services provided by the Veterans' Administration under subsection (a) of this section shall be reimbursed to the Veterans' Administration by the Department of Defense at such rates as may be agreed upon by the Administrator and the Secretary of Defense based on the cost of the care or services provided.

"(2) Amounts received under this subsection shall be credited to funds allotted to the Veterans' Administration facility that provided the care or services.

Plans implementation.

Submittal to congressional committees.

"(d)(1) Not later than six months after the date of the enactment of this section, the Administrator and the Secretary of Defense shall enter into an agreement to plan and establish procedures and guidelines for the implementation of this section. Not later than one year after the date of the enactment of this section, the Administrator and the Secretary shall complete plans for such implementation and shall submit such plans to the Committees on Veterans' Affairs and on Armed Services of the Senate and House of Representatives.

Review and report.

"(2) The Administrator and the Secretary of Defense shall jointly review such plans not less often than annually thereafter and shall report to such committees any modification in such plans within thirty days after the modification is agreed to.

Regulations.

"(e) The Administrator shall prescribe regulations to govern any exercise of the authority of the Administrator under subsections (a) and (b) of this section and of the Chief Medical Director under subsection (b)(2)(A) of this section.

Reports to congressional committees

"(f) Within thirty days after a declaration of a period of war or national emergency described in subsection (a) of this section (or as soon after the end of such thirty-day period as is reasonably practicable), the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the Administrator's allocation of facilities and personnel in order to provide priority hospital care, nursing home care, and medical services under this section to members of the Armed Forces. Thereafter, with respect to any fiscal year in which the authority in subsection (b) of this section to enter into contracts with private facilities has been used, the Administrator shall report within ninety days after the end of such fiscal year to those committees regarding the extent of, and the circumstances under which, such authority was used.".

(b) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 5011 the following new item:

"5011A. Furnishing of health-care services to members of the Armed Forces during a war or national emergency.".

Sec. 5. (a) Section 1786(a) of title 38, United States Code, is amended by adding at the end the following new paragraph:

"(3) Notwithstanding any other provision of law unless enacted in express limitation of this paragraph, funds in the Veterans' Administration readjustment benefits account shall be available for payments under paragraph (1) of this subsection for pursuit of a program of education exclusively by correspondence in which the veteran or spouse or surviving spouse enrolls after September 30, 1981.".

Effective date.
38 USC 1786 note.

(b) The amendment made by subsection (a) of this section shall take effect as of October 1, 1981.

Richard L. Roudebush Veterans' Administration Medical Center, designation

SEC. 6. The Veterans' Administration medical center located at 1481 West 10th Street, Indianapolis, Indiana, shall after the date of the enactment of this Act be known and designated as the "Richard L. Roudebush Veterans' Administration Medical Center". Any reference to such medical center in any law, regulation, document, map, record, or other paper of the United States shall after such date be deemed to be a reference to the Richard L. Roudebush Veterans' Administration Medical Center.

Approved May 4, 1982.

LEGISLATIVE HISTORY—S. 266 (H.R. 3502):

HOUSE REPORTS: No. 97-72, Pt. I (Comm. on Veterans' Affairs) and Pt. II (Comm. on Armed Services) both accompanying H.R. 3502.
SENATE REPORTS: No. 97-137 (Comm. on Governmental Affairs) and No. 97-196 (Comm. on Veterans' Affairs).
CONGRESSIONAL RECORD:
Vol. 127 (1981): Oct. 27, considered and passed Senate.
Nov. 4, considered and passed House, amended, in lieu of H.R. 3502.
Vol. 128 (1982): Apr. 1, Senate agreed to House amendments with amendments.
Apr. 20, House concurred in Senate amendments.

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